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# Mid-Term Evaluation of the DIALOGUE Project Central Asian Republics

**Conducted by AIDSTAR-Two**

***October 30 – November 30, 2012***

**November 30, 2012**

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## Acronym List

AFEW	AIDS Foundation East-West
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral therapy
BCC	Behavior change communication
BTC	Break the Cycle Program Model
CARHAP	Central Asian Regional HIV/AIDS Program
CCMs	Country Coordinating Mechanisms
CDC	Centers for Disease Control
Dialogue	USAID Dialogue on HIV and TB Project
DDRP	Drug Demand Reduction Program
DU-SWs	Drug-using sex workers
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCP	Health Care Provider
HIP	Health Improvement Project
HIV	Human immunodeficiency virus
HOP	Health Outreach Program (Original name for Dialogue Project)
IDI	In-depth interviews
IEC	Information Education Communication
IOM	International Organization for Migration
IPC	Interpersonal Communications
KAPB	Knowledge, attitudes, perceptions and behaviors
MAT	Medication-assisted treatment
MDR TB	Multi-drug resistant TB
MDT	Multidisciplinary team
MIS	Management Information System
MOH	Ministry of Health
MSM	Men who have sex with men
NGO	Non-governmental organization
NSP	Needle and syringe program
NTP	National TB Program
OST	Opioid Substitution Therapy
PEPFAR	President's Emergency Fund for AIDS Relief
PDI	Peer-driven intervention
PIU	Project Implementation Unit
PLHIV	People living with HIV
PMP	Performance monitoring plan
PWID	People who inject drugs
PY	Project year
PSI	Population Services International
ROC	Regional Oversight Committee
STI	Sexually transmitted infections
TB	Tuberculosis
TOPS	Targeted Outreach Package of Services

TRaC	Tracking Results Continuously
TWG	Technical Working Group
UIC	Unique Identifier Code
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
WHO	World Health Organization

## Executive Summary

The USAID Dialogue on HIV and TB Project is a five-year program (2010-2015) aimed at reducing the spread of the HIV and tuberculosis (TB) epidemics in Central Asia through improving health behaviors among most-at-risk populations (hereafter referred to as vulnerable populations). These include people who inject drugs (PWID), sex workers, men who have sex with men (MSM), people living with HIV/AIDS (PLWHA), prisoners, and migrants.

USAID Dialogue on HIV and TB Project (hereafter referred to as the Dialogue Project), is implemented by a consortium of partners led by Population Services International (PSI) and includes Project HOPE, AIDS Foundation East-West (AFEW), and the Kazakh Union of People living with HIV/AIDS in the Republic of Kazakhstan. The Dialogue Project has contracted over 31 NGOs as implementing partners to deliver its project models to vulnerable populations. Implementing partners are selected by a competitive tender process.

The project's overall goals are:

1. Reduction in risk behaviors associated with HIV transmission
2. Increased use of evidence-based HIV prevention and TB treatment services by vulnerable populations
3. Improved TB case detection among selected vulnerable populations
4. Improved adherence to and decreased default rate from TB treatment among vulnerable populations
5. Increased number of vulnerable populations in Central Asia reached with high-quality outreach services to prevent HIV and the spread of TB.

This evaluation comes at the midpoint of the Dialogue Project, and as such provides an opportunity to use the evaluation findings to guide implementation of the second half of the project. The evaluation covers years 1, 2 and 3 of the project. The overriding purpose of this evaluation is to obtain an independent appraisal on project performance in order to determine whether or not and to what extent project approaches and activities have been successful and to use this information to make any necessary adjustments. The audiences of the evaluation report are USAID/CAR Mission and the Dialogue Project consortium. To this end, the evaluation:

- Assessed the project's approach and methodology to achieve project objectives
- Reviewed and validated project-reported accomplishments as per outputs established in the Cooperative Agreement and related monitoring plans with USAID/CAR
- Assessed the effectiveness and impact of the technical assistance, training, and grant activities

This was achieved by undertaking a desk review of relevant documents, developing a logic model for the project, in-country site visits to interview implementing partners and project beneficiaries, and a final synthesis and analysis of all findings.

In order to determine if goals are on target to being achieved, the evaluation team cross-referenced the answers to the principal evaluation questions to the Dialogue Project goals. This process revealed the following results:

**Table 1: Status of Dialogue Project Goals as of November 2012**

<b>Program Goals and Their Status at the Conclusion of the Evaluation</b>			
<i>Program goals</i>	<i>On track to be achieved</i>	<i>Issues to be resolved to achieve</i>	<i>Not achieved</i>
<b>Reduction in risk behaviors associated with HIV transmission</b>		Kazakhstan MSM decrease in condom use	
		No data for PWID	
<b>Increased use of evidence-based HIV prevention and TB treatment services by vulnerable populations</b>	Voluntary counseling & testing numbers increased for PWID, MSM, SW, PLHIV & Prisoners		
<b>Improved TB case detection among selected vulnerable populations</b>	PWID & PLHIV significant increase in testing and detection		
<b>Improved adherence to and decreased default rate from TB treatment among vulnerable populations</b>			Based on field observations, TB adherence & treatment are not improving significantly (particularly among PWID). MIS data corroborate this finding but are being investigated for reporting problems.
<b>Increased number of vulnerable populations in Central Asia reached with high-quality outreach services to prevent HIV and the spread of TB</b>	Increased numbers of vulnerable populations reached across entire program		

## **Overall Key Findings for Dialogue Project**

### **Reach**

The Dialogue Project employs five different outreach prevention models that have been proven effective under previous regional projects and deemed best practices. Each model is tailored to specific program needs for a specific target population and then scaled-up across the region over the course of the project. The outreach models and their respective “targeted outreach package of services” (TOPS)

are effective for reaching a large number of vulnerable populations with quality outreach services to prevent HIV and the spread of TB. TOPS consist of prevention information-education activities based on the peer education principle; referral system to medical and social services; and case management services to program clients for treatment adherence support. They have contributed to reducing risk behaviors, increasing use of HIV prevention and treatment services, and improving TB case detection. Specifically, where the “UNISON Model” has been implemented – this is an integrated service delivery model for PLHIV – HIV testing has increased among PLHIV in Kyrgyzstan and Tajikistan, and TB testing has increased among PLHIV in all three countries evaluated in this study: Kazakhstan, Kyrgyzstan and Tajikistan. Where the “LaSky” HIV prevention model for MSM has been implemented, condom use among MSM has increased in all countries except Kazakhstan. HIV testing, in contrast, has not increased with this model. Where the “START Plus” integrated HIV/TB service delivery model has been used among prisoners, HIV testing has increased in all three countries, particularly in Kazakhstan and Kyrgyzstan.<sup>1</sup>

Project interventions have been less effective in improving adherence to and decreasing default from TB treatment. With the exception of PLHIV in Tajikistan, TB adherence and treatment completion has decreased among PWID and PLHIV in all three countries.

### **Knowledge, Attitudes and Behaviors**

Knowledge of HIV transmission has increased among prisoners and PLHIV in all three countries, and among MSM in Kyrgyzstan.<sup>2</sup> Changes in vulnerable population attitudes regarding HIV transmission have not been measured, although some project activities have been directed to changing these attitudes, and considerable effort has been placed on changing the attitudes of service providers (which should contribute to improved vulnerable population attitudes). Behavior change longitudinal data are currently available only for MSM from the TRaC studies conducted in PY1 and PY3. Among MSM, Dialogue Project interventions are associated with behavior changes in regard to condom use in all three countries combined and in regard to HIV testing in Kyrgyzstan and Tajikistan.

### **Data Use**

Overall, both annual and quarterly performance reports contain very extensive and high quality information on the implementation of the project in the respective countries including the key challenges faced by the partners. Similarly, proposed yearly implementation plans contain country-specific outline of activities to be carried out during the upcoming period. Tracking Results Continuously (TRaC) studies include both key and extensive recommendations that are developed to inform and guide implementation, and all implementing partners have been provided with and trained in the use of program MIS. However, while in general the implementation of the project in Kazakhstan, Kyrgyzstan, and Tajikistan followed the implementation plans, there were a few issues/activities that have either been left unaddressed or have not been followed to the full extent.

The evaluation team also noticed the lack of a strong and consistent connection between the recommendations from TRaC surveys and information and education materials provided by the Dialogue Project to its beneficiaries; for example, MSM IEC materials reflected the need for more information on negotiating safer sex. Finally, the project has generated a considerable amount of data through the MIS, TRaC, and most recently with FoQus. However, comparative data over time to measure progress toward

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<sup>1</sup> Data will only be available in PY5 regarding the effectiveness of project interventions for sex workers and PWID.

<sup>2</sup> TRaC Survey 2011

reaching project goals is scanty, since much of this data is planned to be obtained at the end of the project.

### **Integration of HIV/TB/Drug treatment**

The Dialogue Project was the first project to systematically address the issue of HIV and TB services integration in Central Asia. One of project's main achievements is that the TB issue for vulnerable populations was considered.

In order to succeed, the Dialogue Project implemented numerous advocacy activities such as working with the Republican AIDS Centers to endorse the Dialogue referral voucher, building partnerships, and impelling structural changes to health care systems in the region. However, the process of integration is far from complete. Large scope harm reduction programs supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) do not include TB prevention and detection services. There are no health care facilities where people with multiple diagnoses can receive diagnostics and treatment services on a one-stop shop basis. The vertical and highly centralized post-Soviet health system in Kyrgyzstan constitutes a structural barrier for TB and HIV treatment adherence for people with HIV/TB coinfection and drug abuse problems.

### **Sustainability**

Project models and results appear to be partially sustainable, with some of the models and approaches having already been adopted by the national authorities such as the voucher system in all countries. The referral and voucher system is functioning very well in Kazakhstan, Kyrgyzstan, and Tajikistan. Over the past three years, implementing partners have gained substantial experience in implementing Dialogue models, and the implementation of the UNISON Multidisciplinary approach to treatment adherence among PLHIV has led to a considerable improvement in care of PLHIV.

Furthermore, implementing partners improved their capacities in outreach, case management, and data management,<sup>3</sup> and are now better positioned to compete for funding. However, major obstacles to the sustainability of project models and results remain in all three countries. Without a sustained funding base, the sustainability of the majority of implementing partners as well as of the services they provide will be significantly undermined. It is highly unlikely that governments in Kyrgyzstan or Tajikistan will fund programs for vulnerable populations and a significant advocacy effort will be required in Kazakhstan to convince the government to fund vulnerable populations through its NGO grants scheme. Similarly, referral and voucher systems can become fully sustainable only if voucher-entitled services are supported financially. Despite a significant number of trainings that have already been provided to implementing partners, there is still room for improvement of the quality of services and more capacity building is needed to better position these local partners to succeed following the completion of the project.

## **Key Findings for Kazakhstan**

Dialogue Project activities in Kazakhstan are implemented in Almaty, Temirtau, Karaganda, South Kazakhstan (Shymkent) and East Kazakhstan (Ust-Kamenogorsk) under the leadership of PSI, together with Project Hope, AFEW and the Kazak Association of People Living with HIV/AIDS. The project has

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<sup>3</sup> Dialogue Annual Report Year 3

reached a significant number of vulnerable populations through its outreach activities, and is well along the way to surpassing its targets for these groups by PY4 (October 2012 to September 2013). More specifically, in its first three years the project has reached more than 22,000 individuals from vulnerable populations, including 6,467 PWID, 1,817 sex workers, 500 migrants, 2,403 MSM, 9,840 prisoners, and 3,110 PLHIV. This represents 88% of the project target of 25,237 individuals in vulnerable populations.

Condom use and HIV testing have improved among prisoners and TB testing has improved among PLHIV.<sup>4</sup> Changes in MSM behavior have been harder to achieve. A major challenge for the remainder of the project is strengthening support for TB treatment adherence and completion.

## **Key findings for Kyrgyzstan**

Dialogue Project activities in Kyrgyzstan are implemented in four project sites of Chui Oblast, Osh Oblast, Jalalabad Oblast, and Bishkek city, under the leadership of PSI Central Asia, together with Project Hope and AFEW. The project has reached more than 24,638 individuals in vulnerable populations in its first three years here, which is 83% of the project target of 29,692 individuals in vulnerable populations.

According to the project's MIS, condom use, TB testing, knowledge on HIV transmission, and knowledge that TB is curable have improved among PLHIV. The MIS also indicates that HIV testing and knowledge that TB is curable have also improved among prisoners. Accordingly to TRaC surveys, condom use, HIV testing, and knowledge on HIV transmission have improved among MSM.

Project beneficiaries expressed their appreciation of the comprehensive services they can receive anonymously and free of charge through the voucher referral system. In particular, remarks from individual PWID noted an appreciation for the overdose prevention activities, including Naloxone distribution and use of drop-in centers' facilities. PWID former prisoners testified to the positive changes that the START Plus model had brought to their lives, including referrals to NGOs working with PWID. The UNISON model was highly appreciated by PLHIV as it enabled them to receive comprehensive diagnostics, treatment, and social support services. MSM recognized the establishment of the Kyrgyz MSM community as one example of the Dialogue Project's achievements in the country.

The Kyrgyzstan country project piloted promising models that might be scaled up in the region, including the introduction of MDT work (UNISON model) at the level of primary health care centers; institutionalization of continuous education for health care providers; tailoring services for different subgroups of MSM; and a referral system inside NGOs' network for tracking former prisoners, so they would not be lost after their release.

However, there are also some challenges. A major challenge for the remainder of the project is strengthening support for TB treatment adherence and completion. Both MIS PMP indicators and feedback received from implementers during the evaluation demonstrated that these project targets are hard to achieve under existing conditions by means of community support actions only. There is a need for deeper integration of HIV/TB/MAT services. Another issue is scale up and sustainability of the introduced models. Police harassment as well as stigma and discrimination within the health care system remain obstacles for project activities.

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<sup>4</sup> Source: MIS

## Key findings for Tajikistan

Dialogue activities in Tajikistan are implemented in five key program sites of Dushanbe, Vakhdat District, Qurghonteppa, Kulob and Khudjand under the leadership of PSI, together with Project Hope, AFEW and in partnership with the International Office for Migration. The project has reached a significant number of vulnerable populations through its outreach activities. In total, 22,824 people representing vulnerable populations were reached by the Dialogue Project in its first three years of implementation; this number represents 71% of the project target of 32,114 people.

Project beneficiaries expressed their appreciation of and satisfaction with referrals for services such as VCT, testing for sexually transmitted infections (STIs), drug free treatment and drop-in centers, and TB testing and treatment services. They stressed that the introduction of the voucher system was especially helpful, as was the provision of an escort. Distribution of naloxone to clients was a particularly important strategy adopted by the project to prevent fatal drug overdoses. The evaluation team heard very encouraging testimonies from clients and outreach workers on the successful use of naloxone throughout project sites. MDT services were particularly appreciated by clients in Dushanbe, suggesting that this was one of the most successful interventions rolled out by the Dialogue Project.

However, the evaluation team identified a number of challenges related to project implementation in Tajikistan. To address those challenges, it is necessary to prioritize sustainability of project models and results; seek greater involvement of the country level working group in addressing advocacy and sustainability issues; advocate for expansion of Opioid Substitution Therapy (OST) and for making OST available at TB in-patient facilities; better address police harassment, abuse and violence towards vulnerable populations; support low-threshold services for women drug users; and provide more IEC materials in Tajik language.

## Recommendations

### Priority Recommendations to assist in achieving program goals

#### 1. Improve adherence to and decrease default rate from TB treatment among vulnerable populations

In conjunction with investigation of the MIS data with regard to TB adherence support and treatment completion, conduct a root cause analysis of the possible reasons for lack of improved TB treatment adherence and default and address the root causes through targeted interventions, such as advocacy for policy changes, refresher training, and direct support for vulnerable populations to reach services.

Advocate for (1) the availability of MAT in TB hospitals and (2) the delivery of TB treatment in the setting that is the most accessible, non-stigmatizing and convenient for the individual PWID, and most likely to promote adherence, as recommended by WHO, UNODC and UNAIDS.<sup>5</sup>

Strengthen the national network of NGOs working with former prisoners or other vulnerable

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<sup>5</sup> WHO. *Policy guidelines for collaborative TB and HIV services for injecting and other drug users: an integrated approach*. 2008

populations (such as PWID), as well as the referral mechanisms among the NGOs to increase adherence to and completion of TB treatment upon release from prison, particularly in Kazakhstan. The referral network in Kyrgyzstan can be used as a model, as it is effective in tracing and following up prisoners regardless of their location in the country.

## **2. Reduce risk behaviors associated with HIV transmission**

Undertake further study to understand why HIV knowledge among MSM in Kazakhstan and Tajikistan decreased during the first three years of the project.

Conduct an evaluation of the effectiveness of training on attitudes and behavior change of health care providers and law enforcement officers.

Undertake further study to understand why MSM who had the highest exposure to project interventions in Kazakhstan had the lowest percentage of VCT service utilization

## **Priority recommendations for project years 4 and 5**

### **1. Further develop and define the Dialogue Project model**

- The Dialogue Project should further develop and refine the logic model developed by the evaluation team by systematically reviewing all inputs and activities and their contribution to desired project outputs and outcomes, determine whether the quantity and quality of inputs and activities are correct and sufficient to produce project outputs and outcomes, and then re-program PY4 and PY5 activities accordingly.
- Discussion should be undertaken to articulate the nature of the Dialogue Project – is it a demonstration program or one that will go to scale? Either conclusion will have an impact on the planning for the project’s final two years.

### **2. Improve coordination/cooperation**

Harmonize outreach models implemented by different development agencies/projects via the regional round table mechanism to ensure smooth handover of a project from one development agency to another.

### **3. Address sustainability Issues**

- Assess the needs in training and other technical assistance of each NGO; develop a road map of capacity building with specific activities to be undertaken in the remaining two years of project implementation.
- Develop sustainability road maps for implementing NGOs.
- Apply the “meaningful Involvement of vulnerable populations” principles to project models and determine how to more effectively create community ownership of the project.

## Introduction

This evaluation comes at the midpoint of the Dialogue Project, and as such provides an opportunity to use evaluation findings to guide implementation of the second half of the project. The USAID Dialogue on HIV and TB Project is a five-year program (2010-2015), funded by the United States Agency for International Development, aimed at reducing the spread of the HIV and tuberculosis (TB) epidemics in Central Asia through improving health behaviors among most-at-risk populations. These populations, referred to as vulnerable populations throughout this report, include people who inject drugs (PWID), sex workers (SWs), men who have sex with men (MSM), people living with HIV/AIDS (PLWHA), prisoners, and migrants.

The USAID Dialogue on HIV and TB Project, hereafter referred to as the Dialogue Project, is implemented by a consortium of partners led by Population Services International (PSI) and includes Project HOPE, AIDS Foundation East-West (AFEW), and the Kazakh Union of people living with HIV/AIDS in the Republic of Kazakhstan. The Dialogue Project has contracted more than 31 NGOs as implementing partners to deliver the Dialogue Project models to vulnerable populations. Implementing partners are selected by a competitive tender process.

The overriding purpose of this evaluation is to obtain independent appraisal on project performance in order to determine whether or not and to what extent project approaches and activities have been successful and to use this information to make any necessary adjustments.

To this end, the evaluation

- Assessed the project's approach and methodology to achieve project objectives
- Reviewed and validated project-reported accomplishments as per outputs established in the Cooperative Agreement and related monitoring plans with USAID/CAR
- Assessed the effectiveness and impact of technical assistance, training, and grant activities
- Made evidence-based recommendations for improving implementation of the Dialogue Project and future USAID/CAR programming on HIV prevention.

The results of the evaluation will also assist the USAID Mission to determine whether additional areas of focus or a shift in strategic approach or implementation would increase the impact of the project.

The audiences for the evaluation report are the USAID/CAR Mission, specifically the health team, M&E Unit, the Dialogue Project consortium and implementing partners. In addition an executive summary and recommendations from this report will be provided to key USG and government stakeholders.

USAID/CAR will use the report to improve its current strategy of providing support to vulnerable populations and to share lessons learned with other stakeholders. The Dialogue Project and its subcontractors will learn about their strengths and weaknesses and adjust the project accordingly.

## Background

HIV infection in the Central Asian Republics (CAR) is concentrated in less than 1% of the population but is expanding rapidly, with annual HIV incidence reported to be rising in all CAR countries with the exception of Turkmenistan, which reports zero HIV cases. Fueled by people who inject drugs (PWID) located in urban centers and along drug transport corridors from Afghanistan through Tajikistan,

Turkmenistan, Uzbekistan, Kyrgyzstan, and Kazakhstan, there are indications that the epidemic is spreading to bridge populations including sex partners of PWID, sex workers, and MSM.

These countries also report epidemic levels of TB among their general populations, above 128 cases per 100,000, and reaching 206 cases per 100,000 in Tajikistan, as well as high and growing rates of multidrug-resistant TB (MDR-TB). According to the Fourth Global Report on Anti-Tuberculosis Drug Resistance Surveillance, Tajikistan and Kyrgyzstan have the third and sixth highest proportions of MDR-TB cases in the world, 16.0 and 14.7 percent, respectively, of newly diagnosed cases. Almost all countries in the CAR region are below the WHO targets for case detection rates and treatment success rates.

The Dialogue Project’s unified, regionally coordinated strategy allows the project partners to achieve project goals and provides a platform for sharing lessons learned and best practices. The project employs five outreach prevention models that have been proven effective under previous regional projects and deemed best practices. These project models include: The Adara model, the Break the Cycle model, the LaSky model, the START Plus model, and the UNISON model.

Each model is tailored to specific program needs for a specific target population and then scaled-up across the region over the course of the project. All models include a basic outreach package of services, including: information-education activities based on the peer education principle; referral system to medical and social services; case management services to project clients; and community-based adherence support for TB patients. Following is a look at each model in more detail.

1. **The Adara model:** This model, which targets sex workers, was developed by PSI under the USAID funded Drug Demand Reduction Program (DDRP) 2002-2008. It was initially aimed at sex workers who are injecting drug users in the Fergana Valley region of Kyrgyz Republic, Tajikistan and Uzbekistan and has been adapted for use in the Dialogue Project.

**Table 2. Overview of Adara model**

<b>Target Population</b>	Street-based and venue-based sex workers who are also injecting drug users and sex workers who are at high risk of using illicit drugs.
<b>Goal</b>	To improve health behaviors and to increase the uptake of friendly medical services for HIV/STI, TB, and drug use prevention and treatment among sex workers.
<b>Objectives</b>	<ul style="list-style-type: none"> <li>• Increase HIV and TB knowledge</li> <li>• Reduce risky sexual behavior</li> <li>• Increase uptake of friendly medical services for VCT, STI testing and treatment services</li> <li>• Increase uptake of the drug rehabilitation and treatment services</li> </ul>

2. **The Break the Cycle model:** The Break the Cycle (BTC) model was also developed under the USAID-funded Drug Demand Reduction Program (DDRP) 2002-2008. BTC is an intervention which aims to reduce the number of people who begin injecting. The model works by targeting people who inject drugs (PWID) and encouraging them to: reduce injecting in front of non-injectors (modeling); reduce discussion about injecting – especially about its benefits – with people who are at risk of trying it; refrain from helping non-injectors learn how to inject drugs; and develop skills for managing requests to give someone their first injection.

**Table 3. Overview of the Break the Cycle model**

<b>Target Population</b>	Male and female active PWID in Kazakhstan, Kyrgyzstan, Tajikistan, Uzbekistan and Turkmenistan: <ul style="list-style-type: none"> <li>• PWID who have been injecting drugs for longer than one month</li> <li>• PWID who have injected drugs at least once within the last six months</li> </ul>
<b>Goal</b>	To improve health behaviors and to increase the uptake of friendly medical services for HIV, TB, hepatitis and drug use prevention and treatment among PWIDs
<b>Objectives</b>	<ul style="list-style-type: none"> <li>• Increase HIV and TB knowledge</li> <li>• Refuse injecting in front of non-injectors (modeling)</li> <li>• Refuse discussion about injecting - especially about its benefits - with people who are at risk of trying injection drug use</li> <li>• Refrain from helping non-injectors learn how to inject drugs</li> <li>• Increase knowledge on prevention of overdose and how to administer first aid</li> <li>• Increase the uptake of VCT, TB testing and treatment, and drug treatment services</li> </ul>

3. **The LaSky Model:** The LaSky “Trusting each other” model was developed by PSI/Russia in 2004 with the main purpose of helping to reduce the incidence of new HIV and other sexually-transmitted infections among gay and MSM populations. An emphasis is placed on community building and creating an environment where the social norm is to adopt safer sexual behaviors.

**Table 4. Overview of the LaSky model**

<b>Target Population</b>	MSM in Kazakhstan, Kyrgyzstan and Tajikistan who have had at least one male sexual partner in the past three months. These include: <ul style="list-style-type: none"> <li>• Club-going males</li> <li>• Men involved in steady relationships</li> <li>• HIV-positive males</li> <li>• Formal and informal male sex workers and their clients</li> <li>• Homeless and jobless men, migrants to big cities</li> </ul>
<b>Goal</b>	To improve health behaviors and to increase the uptake of friendly services for HIV and STI prevention among MSM.
<b>Objectives</b>	<ul style="list-style-type: none"> <li>• Increase HIV/STI knowledge</li> <li>• Reduce risky sexual behavior</li> <li>• Increase uptake of friendly medical services for VCT and STI testing and treatment</li> <li>• Mobilize the MSM community to actively support HIV prevention efforts</li> </ul>

4. **The START Plus model:** This model builds on the AIDS Foundation East West (AFEW) Project START which is an HIV/STI/hepatitis risk reduction program for people returning to the community after incarceration. Project START works with clients, serving as a “bridge” from the correctional facility to society. The program begins 1-2 months before clients are released and continues with clients for three months in the community after they are released from the correctional facility. START Plus builds on this model by incorporating TB Services such as referral for testing and treatment adherence into project activities.

**Table 5. Overview of the START Plus model**

<b>Target Population</b>	Direct outreach within prisons focusing on prisoners who are HIV positive, current TB patients or PWIDs who will soon be released from prisons.
<b>Goal</b>	To improve health behaviors among prisoners and to increase the uptake of medical and social services for HIV/STIs/TB and drug use prevention and treatment among prisoners.
<b>Objectives</b>	<ul style="list-style-type: none"> <li>• Increase HIV/STI/TB/hepatitis knowledge</li> <li>• Reduce risky sexual behavior</li> <li>• Increase the uptake of medical and social services on HIV/STI/TB/ hepatitis testing, treatment and adherence</li> <li>• Improve prisoners’ skills for re-integration into society after release from prison</li> </ul>

5. **The UNISON Model:** The UNISON model is a multidisciplinary approach to treatment adherence among PLHIV. UNISON, developed by Alliance Ukraine, is a patient-centered approach conducted by a multidisciplinary team – doctor, nurse, psychologist, social worker, peer outreach worker and a narcologist. Families of PLHIV are also brought into the team, where possible, for additional support and to build a stable home environment.

**Table 6. Overview of the UNISON model**

<b>Target Population</b>	The target population includes men and women officially registered as HIV positive who may or may not be receiving ARV. Special focus is placed on those people who are also infected with TB.
<b>Goal</b>	To improve health behaviors and to increase the uptake of friendly medical services for TB testing and treatment and associated medical and social services by PLWH.
<b>Objectives</b>	<ul style="list-style-type: none"> <li>• Increase the uptake of friendly medical services for TB testing and treatment and associated medical and social services</li> <li>• Increase the uptake of reproductive health and family planning services for reduced risk of mother-to-child-transmission</li> <li>• Reduce risky sexual behaviors to prevent secondary HIV transmission</li> <li>• Improve early TB case detection</li> <li>• Reduce treatment default rates</li> </ul>

## Methodology

The purpose of this evaluation was to determine whether or not and to what extent project approaches and activities have been successful and to use this information to make any necessary adjustments for the final two years of the project. To achieve this, the evaluation team focused on each of the five Program goals of Dialogue and developed principal evaluation questions that would help to determine whether the program goals had been achieved.

### Program Goals

1. Reduction in risk behaviors associated with HIV transmission
2. Increased use of evidence-based HIV prevention and TB treatment services by vulnerable populations
3. Improved TB case detection among selected vulnerable populations
4. Improved adherence to and decreased default rate from TB treatment among vulnerable populations
5. Increased number of vulnerable populations in Central Asia reached with high-quality outreach services to prevent HIV and the spread of TB.

### Principal Evaluation Questions:

1. What is the logic or “theory of change” underpinning the interventions in the Dialogue Project? (Cross-cutting issue)
2. How effective have project activities been in reaching various vulnerable population groups? (Goal 2)
3. To what extent (quantity and quality) have specific interventions been effective in contributing to the achievement of planned results? (Goal 1, 2, 3, 4, 5)
4. How effective have project activities been in influencing vulnerable population knowledge, attitudes and behaviors that prevent HIV transmission? (Goal 1)
5. To what extent have project activities addressed both perceived and stated needs of beneficiaries (PWID, sex workers, MSM, prisoners, PLWHA and other vulnerable population groups)? (Goal 1, 2, 4)
6. How effectively has the project addressed the integration of HIV/TB/drug treatment? (Goal 3, 4)
7. How effectively has the project used data to monitor its performance and guide implementation? (Cross-cutting issue)
8. Has the Dialogue Project cross-regional consortium structure and division of technical responsibilities contributed to the achievement of results? (Cross-cutting issue)
9. How well has the project coordinated with other donors and projects working with vulnerable populations, and has existing coordination resulted in accelerated progress towards project goals and mission strategic objectives? (Cross-cutting issue)
10. To what extent are project models and results sustainable? (Cross-cutting issue)

To answer the principal evaluation questions and ultimately answer how well the project is doing to date vis-à-vis the five program goals, the mid-term evaluation involved both (1) process evaluation and (2) monitoring of results (outputs and outcomes) as shown in Figure 1 on the following page.

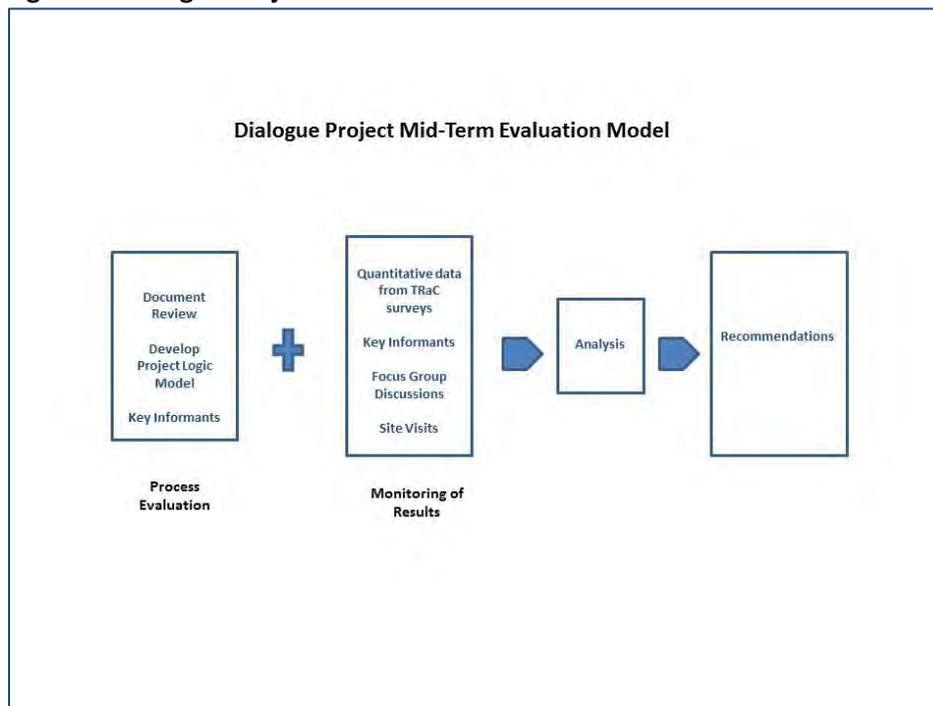
The process part of the evaluation focused on the implementation of the program, although not measuring how effective the activities were. It answers the question about the numbers and types of activities carried out (in relation to the plan), quality of the activities implemented, the reaction of the

target audience (e.g., user or client satisfaction), and problems or obstacles encountered. Some of the principal evaluation questions and sub questions above fall into the category of process evaluation.

The Monitoring of Results (outputs and outcomes) evaluation helped to answer the question about whether the project is making a difference, for example, the project's effect on knowledge, attitudes, skills, behaviors and practices of the target populations or improvements in case detection and adherence and use of services.

The evaluation was conducted at the program level, not at the population level and does not include an impact assessment which is more complex, focusing on population -based measures and experimental design to determine cause and effect.

**Figure 1. Dialogue Project Mid-Term Evaluation Model**



The following data sources informed the evaluation:

- Desk review of relevant documents including the Cooperative Agreement, annual reports, work plans, Performance Management Plan, draft sustainability plan, project model curriculums and training materials, TRaC surveys plus best practice guidance from PEPFAR, UNAIDS and WHO.
- Review of project indicator data against targets
- Semi-structured interviews with representatives of USAID/CAR, CAR country offices and Dialogue Project implementers, representatives of the project consortium partners, and local government officials as appropriate, as well as additional stakeholders in Kazakhstan, Kyrgyzstan, and Tajikistan
- Semi-structured focus group discussions with project beneficiaries
- Visits to project sites/activities such as drop in centers and outreach venues.

## Methodological Limitations

The evaluation team acknowledges a number of limitations to the evaluation process and the effects that these may have had on the issues raised and the recommendations proposed. The issues fall into the following categories

### Physical / Geographical limitations

- The evaluation focused on Kazakhstan, Kyrgyzstan, Tajikistan, and the regional component. Dialogue also had project activities in both Uzbekistan and Turkmenistan, but they potentially may be phased out due to difficult political situations, and logistical restrictions meant it was not possible for the evaluation team to conduct in-country reviews in those two locations. There were also limited opportunities to speak with project implementers or beneficiaries in either Turkmenistan or Uzbekistan via phone or in person. As a result the evaluation team decided that since so little insight could be gathered from either country that they would be excluded from the evaluation. This decision, while pragmatic, will naturally affect the overall outcomes and recommendations of the evaluation.
- Similarly, it was not possible to visit all project implementation sites in the three remaining countries; rather an indicative selection was made that covered all vulnerable populations.

### Process limitations

- The evaluation team initially planned to conduct separate focus group discussions with project beneficiaries. This ultimately proved too difficult due to both logistical and cultural reasons. Given the stigma and discrimination that vulnerable populations face in Central Asia it was not possible to gather 10-15 beneficiaries together to discuss the project. Beneficiaries were wary of this request and it also fell outside of the norms of the project, in which smaller numbers of beneficiaries meet with outreach workers and other project staff, rather than alone. This meant that discussions held with beneficiaries always took place in smaller numbers and with project staff in attendance. The dependent relationship that exists between beneficiaries and implementers/sub-grantees also had the potential to introduce additional bias. Discussions also took place within the context of outreach work such as at “shooting galleries” for PWID which also limited the more formal approach of structured focus group discussions.
- A range of data was available to the evaluation team from many sources, including the annual reports, TRaC surveys, PMP and MIS. However there were inconsistencies with the data and indicators used, which made it difficult for the evaluation team to easily compare baseline data with follow up data to determine if goals/targets and other indicators had been reached. The team did the best it could in the limited time available to try and address some of the data issues, but recognize that errors may have resulted in some of the data analysis.
- The use of interpreters to overcome language barriers could also have affected the outcomes of the evaluation. Interpreters were used in all in-country project visits and the interpreters all had different skill levels and familiarity with the subject matter. Fortunately the evaluation team consisted of Russian (and Tajik) language speakers who were able to assist the interpreters if they were having difficulty in translating technical issues.

## Progress toward Achieving Program Goals

In order to determine if program goals are on target to being achieved, the evaluation team cross referenced the answers to the principal evaluation questions to the Dialogue Program Goals. This process revealed the following results illustrated in Table 7:

**Table 7: Status of Dialogue Project Goals as of November 2012**

<b>Program Goals and Their Status at the Conclusion of the Evaluation</b>			
<i>Program goals</i>	<i>On track to be achieved</i>	<i>Issues to be resolved to achieve</i>	<i>Not achieved</i>
<b>Reduction in risk behaviors associated with HIV transmission</b>		Kazakhstan MSM decrease in condom use	
		No data for PWID	
<b>Increased use of evidence-based HIV prevention and TB treatment services by vulnerable populations</b>	Voluntary counseling & testing numbers increased for PWID, MSM, SW, PLHIV & Prisoners		
<b>Improved TB case detection among selected vulnerable populations</b>	PWID & PLHIV significant increase in testing and detection		
<b>Improved adherence to and decreased default rate from TB treatment among vulnerable populations</b>			Based on field observations, TB adherence & treatment are not improving significantly (particularly among PWID). MIS data corroborate this finding but are being investigated for reporting problems.
<b>Increased number of vulnerable populations in Central Asia reached with high-quality outreach services to prevent HIV and the spread of TB</b>	Increased numbers of vulnerable populations reached across entire program		

The recommendations made in this evaluation have been designed to address the shortfalls in goal achievement.

The following section of the report discusses the specific findings that have led to the above conclusions.

## Findings

This section of the Report discusses the findings of the evaluation. A “whole of project” approach was taken, with the in-country field trips informing the project as a whole rather than there being reports for each country program. This section is organized according to the **Principal Evaluation Questions**. Each question is answered separately below. Data sources are cited and with findings and recommendations provided.

### **1. What is the logic model or “theory of change” underpinning the interventions in the Dialogue Project?**

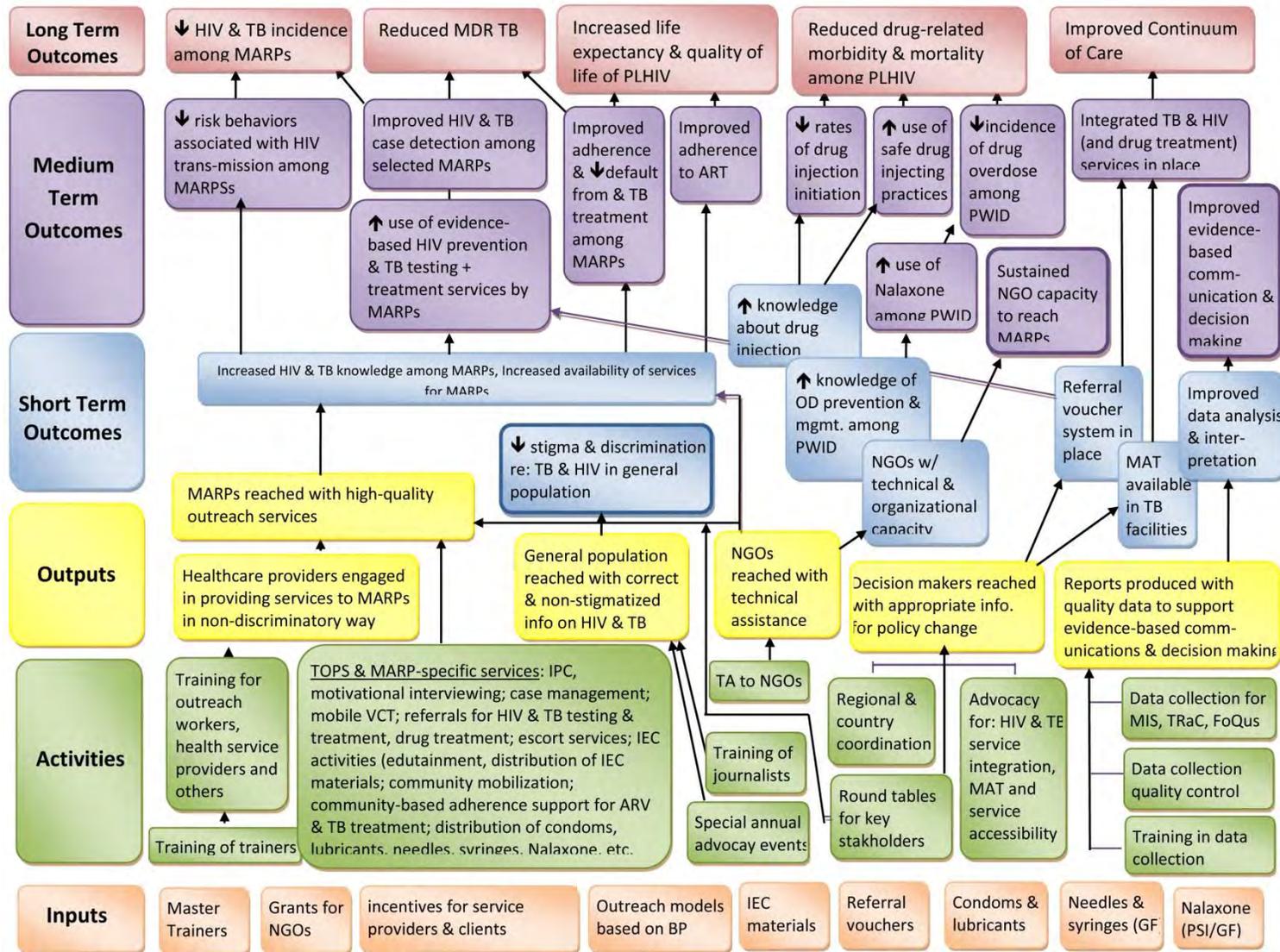
A logic model (also known as logical framework or log frame) is a tool used most often by managers and evaluators of programs to evaluate the effectiveness of a program. It is also frequently used for planning programs. Logic models are usually a graphical depiction of the logical relationships between the inputs, activities, outputs and outcomes of a program. The underlying purpose of constructing a logic model is to assess the "if-then" (causal) relationships between the elements of the program; if the resources (inputs) are available for a program, then the activities can be implemented, if the correct activities are implemented successfully then certain outputs and outcomes can be expected.

One of the key insights of the logic model is the importance of measuring final outcomes or results, because it is quite possible to waste time, money and staff (inputs) on work activities, or produce outputs without achieving desired outcomes. A logic model helps us make the links between all aspects of the program and identify gaps or outlying inputs or activities that may not be contributing to the overall outcomes of the project.

The Dialogue Project did not have a formal logic model at the time of the evaluation, and thus it was not easy to see the casual relationship between inputs/activities and outputs and outcomes. By analyzing the cooperative agreement, work plans, log frame and annual reports of the project, the evaluation team was able to develop an initial logic model which attempted to identify these causal relationships. This model is depicted in Figure 2 on the following page.

The Dialogue Project team will need to revise the model moving into PY4 and PY5.

Figure 2. Dialogue Project Logic Model



The Dialogue Project seems clear on the outcomes and even on the outputs for which there are indicators in the log frame. What is not so clear are the activities linked to those outputs and if those activities are being carried out in sufficient quantity and with sufficient quality to achieve the outputs.

**Recommendation 1.1:** The evaluation team recommends that the Dialogue Project team systematically review all inputs and activities in light of their contribution to desired project outputs and outcomes, determine whether the quantity and quality of input and activities are sufficient to produce project outputs and outcomes, and re-program PY4 and PY5 activities accordingly.

**Recommendation 1.2:** The Dialogue Project should further develop and refine the logic model based on PY4 work plans to better inform programming for PY4 and PY5. Dialogue may consider developing separate logic models for each of the country components to reflect the priorities and issues facing each of the country programs.

## 2. How effective have project activities been in reaching various vulnerable population groups? (Goal 2)

The project activities have been effective in reaching vulnerable populations and increasing utilization of specific HIV and TB prevention and treatment services. Gaps do exist however, especially in maintaining adherence to TB treatment. However, since the program is not at scale, questions must be asked about the overall effect that the project is having on HIV/TB among vulnerable populations in Central Asia. Some gaps in reach have been identified.

The project has contracted more than 31 NGOs to reach the vulnerable populations. Each of these NGOs has implemented a best practice model (described in the introduction) to reach the specific vulnerable population group and over 300 social workers<sup>6</sup>/outreach workers have been trained to conduct direct outreach using interpersonal communication (IPC) and motivational interviewing, and supported by IEC materials developed by the project and the Global Fund. Many of the social workers/outreach workers are themselves from vulnerable populations. A voucher referral system has been put in place to refer clients for needed HIV and TB/STI services and case management has been introduced to strengthen the continuum of care. The net result is that these activities have been effective in reaching the various vulnerable population groups, as demonstrated by the coverage figures below:

**Table 7. Coverage Figures for vulnerable populations: 5-Year Targets**

	PWID	SW	Migrants	MSM	Prisoners	PLWH	TOTAL
Kazakhstan	7,167	2,217	500	2,403	9,840	3,110	<b>25,237</b>
Kyrgyzstan	13,681	5,581	800	1,880	6,735	1,015	<b>29,692</b>
Tajikistan	12,574	10,004	1,000	1,724	5,388	1,424	<b>32,114</b>
Uzbekistan	3,850	1,516	0	0	0	823	<b>6,189</b>
Turkmenistan	3,488	0	0	0	0	0	<b>3,488</b>
<b>TOTAL</b>	<b>37,272</b>	<b>19,318</b>	<b>2,300</b>	<b>6,007</b>	<b>21,963</b>	<b>6,372</b>	<b>96,720</b>

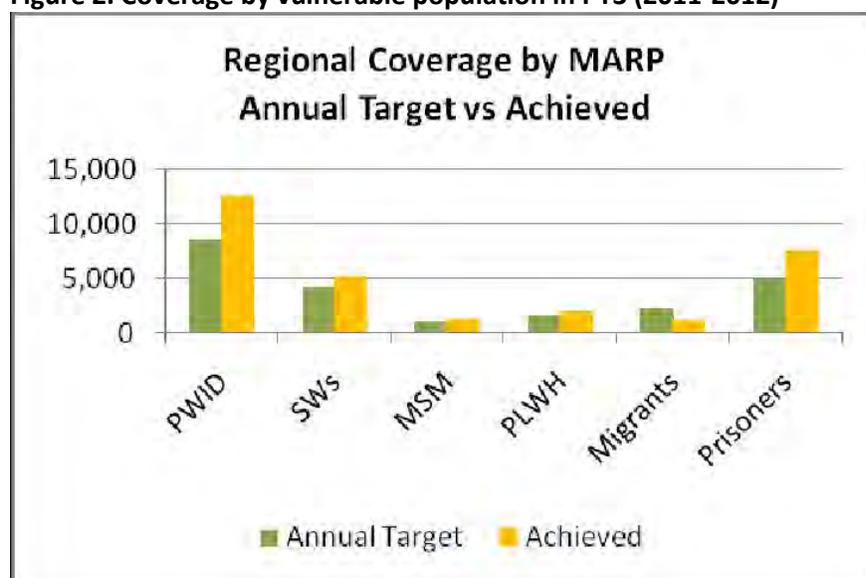
<sup>6</sup> Social work as a recognized “profession” is a new concept for Central Asia. As a result, the title “social worker” does not necessarily refer to the profession in the western concept. For the Dialogue Project, social workers could best be described as health facility based outreach workers.

The Dialogue Project has consistently exceeded its targets, as illustrated in Table 8 below. Figure 2, also below, shows how regional targets were exceeded in PY3, for all groups within vulnerable populations except migrants. As a result of this consistent over achievement, targets were revised upwards for the final two years of the project. Overall targets were increased from 74,223 to 96,720.

**Table 8. Coverage by vulnerable population**

	Year 1	Year 2	Year 3	TOTAL	Original 5-Year Targets	Revised 5-Year Targets
<b>PWID</b>	3,402	15,024	12,558	<b>30,984</b>		37,272
<b>Sex workers</b>	2,144	7,701	5,157	<b>15,002</b>		19,318
<b>Migrants</b>	0	0	1,182	<b>1,182</b>		2,300
<b>MSM</b>	1,205	2,246	1,324	<b>4,775</b>		6,007
<b>Prisoners</b>	2,645	9,374	7,754	<b>19,773</b>		21,963
<b>PLWH</b>	648	2,380	2,006	<b>5,034</b>		6,372
<b>Total</b>	<b>10,044</b>	<b>36,725</b>	<b>29,981</b>	<b>76,750</b>	<b>74,223</b>	<b>96,720</b>

**Figure 2. Coverage by vulnerable population in PY3 (2011-2012)**



The increase in the targets was a concern for project implementers. ‘Chasing’ coverage targets and fulfilling the plans of reaching new clients has put a significant pressure on outreach workers. Very often, they implied that a substantial amount of their time was spent on ‘finding’ and engaging with new clients. With the cumulative number of newly reached clients growing, they were unable to devote an adequate amount of time to those have already been reached, leaving the latter without adequate case management and perhaps not having sufficient time to devote to delivering appropriate messages. Therefore, the quality of work with already reached clients was reportedly suffering as a result of such pressure to fulfill the plans for reaching new clients.

**Recommendation 2.1:** Coverage targets should be reviewed, to better reflect capacity of implementers to provide consistent quality services to both new and existing clients.

Discussion was held with the Dialogue Project team and implementers about the consistent surpassing of targets and why it was occurring. The common themes were that the issue was due to:

- Inconsistent vulnerable population size estimation data for the region, resulting in underestimating vulnerable population sizes. This was evidenced by the discussions about coverage increases. Implementers were not concerned about being able to reach identify new clients as they were only reaching small percentages of vulnerable populations (but were concerned about what effect additional clients would have on the quality of services they could provide).
- Lack of alternate projects providing similar services. In most locations, the Dialogue Project was the only project providing such a comprehensive range of services, and as a result, clients gravitated to the projects.
- Enthusiasm and commitment of the Implementing NGOs to provide services. The evaluators consistently found that implementing NGOs went over and above the scope of their sub contracts by working longer hours, volunteering time and supplementing Dialogue project activities with activities funded through other means. This commitment attracted clients as clients could see that the NGO was committed and genuine in its desire to support vulnerable populations and their needs.

Vulnerable population size estimation data for the region is believed to be under reported but is based on the information in Table 9 below which is a synthesis of estimation data from a variety of sources.

**Table 9. Vulnerable population size estimation for the CAR region**

	Vulnerable populations size estimation by country						Evaluation countries†
	Kazakh- stan	Kyrgyzstan	Tajikistan	Turkmen -istan	Uzbekistan	CAR	
<b>Number of PWID*</b>	119,000	26,000	25,000	33,000	60,000	<b>263,000</b>	170,000
<b>Number of sex workers*</b>	20,000	7,500	8,000	--	30,000	<b>65,500</b>	35,500
<b>Number of MSM*</b>	100,000	3,700	--	--	--	<b>103,700</b>	103,700
<b>Number of prisoners*</b>	52,713	9,600	12,000	22,000	44,025	<b>140,338</b>	74,313
<b>Number of labor migrants</b>		500,000**	1,000,000***	--	2,000,000	<b>3,500,000</b>	1,500,000

†Total vulnerable population size estimation for Kazakhstan, Kyrgyzstan and Tajikistan

\* Republican AIDS Centers, 2010

\*\*The World Bank Migration and Remittances Factbook 2011

\*\*\* IOM

With these estimations it can be seen that the actual reach/scale of vulnerable populations by the Dialogue Project is extremely low, as illustrated in Table 10 on the following page.

**Table 10. Comparison of Dialogue Project reach vs. vulnerable population size estimation**

vulnerable populations	Dialogue Coverage	Size Estimation of population
PWID	37,272	263,000
SW	19,318	65,500
MSM	6,007	103,700
Prisoners	21,963	140,338
<b>Labor Migrants</b>	<b>2,300</b>	<b>3,500,000</b>

UNAIDS estimates, for example, that in order to reverse the epidemic among MSM, programs must reach at least 60% of the MSM population to be effective.<sup>7</sup> Similar reach is required for other vulnerable populations. In this scenario, while the Dialogue Project is effective in reaching its targets and providing its clients with quality services, doubt must exist as to the overall effect that the scale of the Dialogue Project is having on the overall impact of HIV on vulnerable populations in Central Asia.

**Recommendation 2.2** Further discussion should be undertaken to articulate the nature of the Dialogue Project – is it a pilot program or one that will go to scale? Either conclusion will have impact on planning for the final two years of the project

The evaluation also uncovered a number of gaps in coverage which need to be addressed:

- Young PWID. Existing models are not appropriate for young PWID; the BTC model is not clear on how to provide services to this group as the focus of the model is to discourage young people from initiating drug use.
- Female PWID. Gender equity and gender sensitive approaches are, in the main, missing from the project. The BTC model does not provide direction for the specific needs of female PWID and is mainly geared toward male drug users, and as a result, females are under served by the project.
- Sexual partners of PWID. The BTC model is focused on discouraging injection initiation and safe injecting. It does not adequately cover sexual transmission or issues arising for sexual partners of PWID.
- PWID from remote regions are an underserved population.

Among the vulnerable populations reached, a large and increasing number of HIV and TB services are being provided by the project. Service provision targets are also being met and surpassed. The cumulative number of vulnerable populations reached (excluding migrants) with individual and/or small group interventions that are based on evidence and/or meet minimum standards increased from approximately 34,000 to 51,000 from PY 2 to PY3 in the three focus countries of this report.

By the end of PY3, 108% of the cumulative target for the project was met. Likewise, the cumulative number of vulnerable populations (excluding migrants) who were referred and tested for HIV increased from 1,400 in PY1 to more than 12,000 in PY3 in the three countries, reaching 104% of the cumulative project target. With regard to TB testing in the same three countries, the cumulative number of PLWH and PWID referred and tested for TB increased from approximately 500 to 5,500 from PY1 to PY3, with 108% of the cumulative project target accomplished. The increase in TB testing from PY2 to PY3 alone

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<sup>7</sup> Commission on AIDS in Asia. UNAIDS 2009 and others.

was 66%. The cumulative number of PWID referred for drug treatment in the three countries has increased from approximately 200 in PY1 to 2,000 in PY3. With the exception of PY1, annual cumulative targets were met. Last, the cumulative number of vulnerable population TB patients (PWID and PLWH) that have been assisted by community treatment supporters throughout treatment was 519 in PY3 in the three countries, reaching 125% of the project cumulative target.

### **3. To what extent (quantity and quality) have specific interventions been effective in contributing to the achievement of planned results?**

The outreach models and their respective TOPS are effective for reaching a large number of vulnerable populations with quality outreach services to prevent HIV and the spread of TB. They have contributed to reducing risk behaviors, increasing use of HIV prevention and treatment services, and improving TB case detection. Specifically, where the UNISON model has been implemented, HIV testing has increased among PLHIV in all countries, except Kazakhstan, and TB testing has increased among PLHIV in all three countries. Where the LaSky model has been implemented, condom use among MSM has increased in all countries, except in Kazakhstan. HIV testing, in contrast, has not increased where the LaSky model has been implemented. Among prisoners, where the START Plus model has been used, HIV testing has increased in all three countries, and particularly in Kazakhstan and Kyrgyzstan.<sup>8</sup>

Project interventions appear to have been less effective in improving adherence to and decreasing default from TB treatment. According to the MIS, which may be reporting incorrectly,<sup>9</sup> TB adherence and treatment completion has decreased among PWID and PLHIV in all three countries, with the exception of PLHIV in Tajikistan. Regardless, team observations indicate that further attention is needed to improve TB treatment adherence and completion.

#### *a. Reduction of risk behaviors associated with HIV transmission*

**Condom use.** Risk behavior associated with HIV transmission, measured in terms of condom use, has decreased among two vulnerable populations served by the project: MSM and PLHIV. For other vulnerable populations, data concerning changes in condom use will be available in PY5.

Condom use at last anal intercourse with a male partner has increased among MSM from PY1 to PY3 in all three countries where TRaC studies have been conducted, although the improvement was not statistically significant in Kazakhstan.<sup>10</sup> The greatest increase has occurred in Tajikistan, where condom use increased among MSM from 33% to 61% from PY1 to PY3. Condom use among MSM at last anal intercourse is highest in Kyrgyzstan, having reached 71% in PY3 compared to 42% in PY1.

Similarly, condom use among PLHIV at last sexual intercourse has increased in all of the same three countries from PY1 to PY3.<sup>11</sup> The largest increase occurred in Kyrgyzstan, where condom use among PLHIV increased from 36% to 71% from PY1 to PY3. Condom use among PLHIV at last sexual intercourse

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<sup>8</sup> Data will only be available in PY5 regarding the effectiveness of project interventions for sex workers and PWID.

<sup>9</sup> The MIS report for adherence support in the Y3 upgraded MIS is not reporting accurately and is being investigated with hard copy documents.

<sup>10</sup> Source: MSM TraC PY3

<sup>11</sup> Source: MIS

is highest in Tajikistan, having reached 90% in PY3 compared to 80% in PY1. Condom use data is not yet available for sex workers, PWID and migrants, as TRaCs will be conducted for sex workers and PWID<sup>12</sup> in PY5 and condom use began to be monitored for migrants only in PY3.

Both the LaSky model for MSM and the UNISON model for PLHIV include IPC about correct and consistent condom use, distribution of IEC materials that describe correct condom use and condom distribution. IPC, distribution of IEC material and distribution of condoms are also key elements of the Break the Cycle model for PWID. Nevertheless, interviews with PWID and outreach workers indicate that insufficient emphasis has been placed on preventing sexual transmission of HIV among PWID. Primary emphasis has been placed on harm reduction among PWID, and prevention of sexual transmission of HIV has been of secondary concern. Given the high incidence of injecting drug use and that sexual partners of PWID are “bridge populations” that facilitate HIV transmission to the general population, stronger prevention efforts need to be placed on sexual transmission of HIV by PWID, focusing not only on PWID themselves but also their sexual partners. The Dialogue Project might consider development of an outreach model and targets for sexual partners of PWID, although the evaluation team recognizes the time and resource constraints (for example, training and changes in the MIS) that this would require.

**Finding:** Insufficient attention is being paid to sexual transmission of HIV among PWID in project interventions.

**Recommendation 3.1:** Intensify interventions to prevent sexual transmission of HIV among PWID.

**Recommendation 3.2:** Identify and implement feasible interventions that can be undertaken in the last two years of the project to reach sexual partners of PWID.

**Sharing injecting equipment:** Since the TRaC surveys among PWID will be conducted in PY5, comparative project data are not yet available on harm reduction and the evaluation team was thus unable to determine the effect of project interventions on reductions in the sharing of drug injecting equipment. Findings from interviews with PWID clients and outreach workers, however, indicate that the BTC model IEC harm reduction components (IPC, distribution of IEC materials and motivational interviewing) are being implemented. PWID are particularly attracted to harm reduction interventions when they include distribution of naloxone for overdose prevention and drop-in centers (in the case of Kyrgyzstan and Tajikistan), where they can solve their basic needs, such as accommodations and hygiene.

*b. Increased utilization of evidence-based HIV prevention and TB treatment services by vulnerable populations*

**HIV testing.** HIV testing has increased considerably among MSM served by the project in Kyrgyzstan and Tajikistan and decreased in Kazakhstan.<sup>13</sup> It has also increased among prisoners in all three countries.<sup>14</sup> For the remaining populations, data concerning changes in HIV testing will be available in PY5.

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<sup>12</sup> TRaCs were conducted in PY3 for sex workers and PWID but they cannot be compared to the PY1 TRaCs conducted for the same groups because they used a simplified methodology in order to provide a mid-project “snapshot” of sex workers and PWID.

<sup>13</sup> Source: MSM TRaC PY3

<sup>14</sup> Source: MIS

In Kyrgyzstan, 62% of MSM had received HIV testing and counseling and received their test results in the last 12 months in PY3, compared to 26% in PY1. In Tajikistan, 49% of MSM had been tested for HIV and received their results in PY3, compared to 14% in PY1. The reason for the decrease in HIV testing among MSM in Kazakhstan, from 38% in PY1 to 32% in PY3, is unknown. Interviews with outreach workers indicate that some MSM continue to distrust HIV testing facilities for fear they will experience discrimination. Even though the MSM NGO Adali in Almaty has developed an effective referral system for MSM to the Almaty AIDS center where a MSM-friendly physician cares for MSM, the NGO has begun testing for HIV at its headquarters office. Adali uses HIV rapid tests provided by the Almaty AIDS Center, in an attempt to increase the uptake of HIV testing among MSM.

**Finding:** MSM continue to feel stigmatized and discriminated when seeking health services, including HIV testing.

**Recommendation 3.3:** Incorporate HIV rapid tests into the interventions of NGOs providing outreach to MSM (and other vulnerable populations, as needed), where policy permits.

**Recommendation 3.4:** Further strengthen training of health service providers regarding stigma and discrimination toward MSM.

In all three countries, more than 75% of the prisoners reached by the project have been tested for HIV and received their results in the last 12 months.<sup>15</sup> During PY1, 16%, 25% and 72% had been tested in Kyrgyzstan, Kazakhstan and Tajikistan, respectively. The high proportions of prisoners tested for HIV is testimony to the wider availability of HIV testing in prisons since project inception. In Kyrgyzstan, NGOs transported AID Center staff to prisons to conduct HIV testing. In both Tajikistan, where HIV testing is compulsory, and in Kazakhstan, prison health personnel are responsible for HIV testing. The Dialogue Project appears to have brought visibility to HIV testing in prisons.

All outreach models incorporate referrals for HIV testing. Interviews with clients (non-prisoners) suggest that both the use of referral vouchers, which allow the clients to be tested free-of-charge and without revealing their identity, and the use of social escorts, when needed, provide security to the clients that they will be tested with minimal questioning and at no cost.

**TB testing.** TB testing has increased during the first three years of the project among PLHIV.<sup>16</sup> Comparative data for PWID will only be available in PY5. (Active outreach for TB testing among MSM and sex workers was discontinued mid-project.)

The proportion of PLHIV who have been tested for TB in the last 12 months increased in all three countries between PY1 and PY3: from 25% to 92% in Kyrgyzstan, from 31% to 93% in Tajikistan, and from 80% to 89% in Kazakhstan. The UNISON model includes referrals for TB testing using the voucher system. As with HIV testing, the referral vouchers, which allow TB testing to be provided free of charge, contributed greatly to the increase in coverage in TB testing among PLHIV, according to outreach workers. Also, the use of case management and social escorts, together with the placement of TB specialists in AIDS Centers (in the Almaty AIDS Center, for example), were also reported to have contributed to wider coverage of TB testing.

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<sup>15</sup> Source: MIS

<sup>16</sup> Source: MIS

*c. Improved adherence to and decreased default from TB treatment among vulnerable populations*

Improved TB treatment adherence and reduced default from TB treatment is one project result that may not be progressing toward achievement of the project goal. According to MIS data, among PWID and PLHIV, the proportion enrolled in Dialogue Project adherence support that completed TB treatment decreased in both Kazakhstan and Kyrgyzstan from PY1 to PY3. The largest decreases in these two countries were among PLHIV. For example, the percentage of PLHIV enrolled in Dialogue Project TB treatment adherence support that completed TB treatment fell from 67% to 46% in Kazakhstan between PY1 and PY3. TB treatment adherence and default improved only in Tajikistan among PLHIV. (Data is not available for TB adherence and treatment completion among PWID in Tajikistan.) However, the MIS report for adherence support in the PY3 upgraded MIS is not reporting accurately and is being investigated with hard copy documents.

MIS data reporting problems apart, field observations by the evaluation team point to difficulties to achieving the project goal with regard to TB adherence and treatment completion. Interviews with outreach workers and clients indicate that TB treatment and adherence support is the weakest link in the continuum of TB and HIV care, in spite of the training that has occurred for outreach workers and for community leaders on community mobilization for TB prevention and treatment support.

**Finding:** TB treatment adherence and default do not appear to be improving among PWID and PLHIV.

**Recommendation 3.5:** In conjunction with investigation of the MIS data with regard to TB adherence support and treatment completion, conduct a root cause analysis of the possible reasons for lack of improved TB treatment adherence and default and address the root causes through targeted interventions, such as advocacy for policy changes, refresher training, and other activities.

One of the factors that makes adherence difficult for PWID, in particular, is that most TB patients are admitted to TB hospitals for the first two months of TB treatment. PWID do not want to remain hospitalized during the two-month in-patient period since it is difficult to inject drugs while hospitalized and because there is no MAT available in TB hospitals.

**Finding:** In-patient treatment for the first two months of TB treatment and the lack of MAT in TB hospitals impedes PWID from adhering and completing TB treatment.

**Recommendation 3.6:** The project should advocate for (1) availability of MAT in TB hospitals and (2) delivery of TB treatment in the setting that is the most accessible, non-stigmatizing and convenient for the individual PWID, and most likely to promote adherence, as recommended by WHO, UNODC and UNAIDS.<sup>17</sup>

While TB treatment adherence and default data for prisoners are not presented here, support for TB treatment adherence and completion is challenging among this vulnerable population group by the fact that many prisoners do not remain in the target area of the NGO that provides the outreach services once they are released from prison. This is particularly true in Kazakhstan where, for example, 85% of the prison population attended by Kredo in Karaganda disperses to other regions of the country upon

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<sup>17</sup> WHO. *Policy guidelines for collaborative TB and HIV services for injecting and other drug users: an integrated approach*. 2008.

release from prison. To address this problem in Kyrgyzstan, there is a strong referral system among NGOs to refer prisoners once they are released from prison. In Tajikistan, the NGO Vita also reported that it obtains the list of prisoners soon to be released and is able to have an ad hoc referral system within the network of NGOs serving prisoners.

**Finding:** High mobility of prisoners after release from prison impedes support for TB treatment adherence and completion on the part of NGOs and their outreach workers.

**Recommendation 3.7:** Strengthen the national network of NGOs working with former prisoners, or other vulnerable populations (such as PWID), and referral mechanisms among the NGOs to increase adherence to and completion of TB treatment upon release from prison, particularly in Kazakhstan. The referral network in Kyrgyzstan can be used as a model.

**Additional considerations in regard to outreach interventions with vulnerable populations:**

The evaluation team is concerned that some outreach workers, who are vulnerable populations themselves, may mix their personal and professional lives. While conducting outreach, workers should not use drugs or engage in sexual activity with clients. Outreach workers should be made aware of and adhere to an outreach code of conduct developed by the project.

**Finding:** Some outreach workers, who are vulnerable populations themselves, may mix their personal and professional lives while conducting outreach.

**Recommendation:** A code of conduct for outreach workers, both paid and volunteers, should be developed and included in all outreach orientation training

## **4. How effective have project activities been in influencing vulnerable population knowledge, attitudes and behaviors that prevent HIV transmission?**

Knowledge of HIV transmission has increased among PLHIV and prisoners in all three countries and among MSM in Kyrgyzstan. Changes in vulnerable population attitudes regarding HIV transmission have not been measured, although some project activities have been directed to changing vulnerable population attitudes and considerable effort has been placed on changing attitudes of service providers (which should contribute to improved vulnerable population attitudes). Behavior change longitudinal data are currently available only for MSM from the TRaC studies conducted in PY1 and PY3. Among MSM, Dialogue Project interventions are associated with behavior changes in regard to condom use in all three countries combined and in regard to HIV testing in Kyrgyzstan and Tajikistan.

**Changes in knowledge of HIV transmission.** Knowledge of HIV transmission has increased among PLHIV and prisoners in all three countries<sup>18</sup> and among MSM in Kyrgyzstan.<sup>19</sup> For sex workers and PWID, data concerning changes in knowledge of HIV transmission will be available in PY5.

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<sup>18</sup> Source: MIS

<sup>19</sup> Source: MSM TRaC PY3

The Dialogue Project measures HIV transmission knowledge as the percentage of vulnerable populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. Of all vulnerable populations, HIV knowledge is highest among prisoners, reaching 100% in Kazakhstan and Tajikistan in PY3, compared to 88% and 73% in PY1, respectively. HIV knowledge is also high among PLHIV, reaching 92% in both Kazakhstan and Kyrgyzstan and 86% in Tajikistan in PY3, compared to 75%, 60% and 64%, respectively, in PY1. HIV knowledge among MSM increased in Kyrgyzstan from 86% to 96% from PY1 to PY3. In contrast, HIV knowledge decreased remarkably during the same time among MSM in Kazakhstan, from 95% to 53%, and less so in Tajikistan, from 87% to 80%.<sup>20</sup> Sampling procedures and the sensitive nature of the TRaC survey questions may have influenced this result. The drop in knowledge may also be due to the ability of outreach workers to reach the most hard-to-reach MSM who may have a lower knowledge base. These assertions will need to be investigated further.

**Finding:** HIV knowledge decreased considerably among MSM in Kazakhstan and Tajikistan from PY1 to PY3.

**Recommendation 4.1:** Undertake further study to understand why HIV knowledge among MSM in Kazakhstan and Tajikistan decreased during the first three years of the project.

**Changes in attitudes with regard to HIV transmission.** Dialogue's sources of data for project monitoring and evaluation (TRaC and MIS) do not monitor changes in vulnerable population attitudes with regard to HIV transmission. Nevertheless, several project interventions are directed to changing attitudes, such as counseling and self-support groups for PLHIV on accepting one's positive status and overcoming internal (self) stigma and community mobilization of MSM for creating an environment where the social norm is to practice safer sex. The most important project intervention to change vulnerable population attitudes (and behaviors) centers on changing the attitudes (and behaviors) of health care providers, law enforcement officers and others who come into contact with the vulnerable populations. Nearly 1,000 service providers have been trained in stigma reduction and communication skills with vulnerable populations in the first three years of the project. For the evaluation team, it is unclear whether this investment in changing provider attitudes and behavior has contributed to the desired change in vulnerable population attitudes and behavior. All of the providers with whom the evaluation team met displayed positive attitudes toward vulnerable populations, although most received financial incentives to participate in the project as part of multi-disciplinary teams and were (obviously) very supportive of the project interventions and its beneficiaries.

**Finding:** Dialogue does not monitor changes in attitudes among vulnerable populations, although considerable effort is placed on changing the attitudes (and behavior) of service providers, law enforcements officers and others, whose attitudes (and behavior) affect vulnerable population attitudes (and behavior) toward HIV transmission.

**Recommendation 4.2:** Conduct an evaluation of the effectiveness of training provided to health care providers and law enforcement officers on changes in their attitudes and behaviors.

To conduct the evaluation, Dialogue should consider a two-prong approach: (1) utilizing clients to evaluate the attitudes and behaviors of healthcare providers when receiving health services and of law enforcement officers when in contact with them and (2) a survey of health care provider and law

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<sup>20</sup> Source: MSM TRaC PY3

enforcement officer attitudes and behavior. The results of the two approaches should be used together to re-design the training provided to both groups and identify other interventions that might be needed to change the attitudes and behavior of health care providers and law enforcement officers.

**Changes in behavior with regard to HIV transmission.** Behavior change longitudinal data are currently available only for MSM from the TRaC studies conducted in PY1 and PY3. Among MSM, Dialogue Project interventions are associated with behavior changes in regard to condom use in all three countries combined and in regard to HIV testing in two of the three countries.<sup>21</sup>

The most recent TRaC conducted among MSM analyzed how the behavior of MSM with no exposure to project interventions compared to those with low and high exposure. In all three countries, the higher the exposure to Dialogue Project interventions, the higher the percentage of MSM who used a condom from start to finish during last anal sex with another man<sup>22</sup> (see Appendix V). A significant difference in consistent condom use among MSM with regular and casual partners was also found according to the level of exposure to Dialogue Project interventions. Condom use with commercial partners was not associated with level of exposure to project interventions. However, the number of MSM reporting commercial partners was low and may have affected the result (see Appendix V).

VCT utilization, defined as being tested for HIV and receiving the results in the last 12 months, increased with exposure to project interventions in Kyrgyzstan and Tajikistan, but not in Kazakhstan. The higher sample size of high-exposure MSM in Kazakhstan compared to the other exposure levels may have affected the result (see Appendix V).

**Finding:** VCT utilization defined as being tested for HIV and receiving the results in the last 12 months, showed no relation to exposure to project interventions among MSM in Kazakhstan, although the large sample size of men exposed to Dialogue Project interventions (compared to other exposure levels) may have influenced this result.

**Recommendation 4.3:** Dialogue Project staff should undertake further study to understand why MSM who had the highest exposure to project interventions in Kazakhstan had the lowest percentage of VCT service utilization.

## **5. To what extent have project activities addressed both perceived and stated needs of beneficiaries (PWID, sex workers, MSM, prisoners, PLWHA, and other vulnerable population groups)? (Goal 1, 2, 4)**

The Dialogue Project appears to be meeting most of the perceived and stated needs of beneficiaries; however gaps do exist, as identified by both the beneficiaries and by comparing project models to best practice approaches.

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<sup>21</sup> MSM TRaC PY3

<sup>22</sup> The differences in condom use by MSM were statistically significant among different levels of project exposure (high, low and no exposure) in Kazakhstan and Kyrgyzstan. In Tajikistan, the difference in condom use was statistically significant among those MSM who had been exposed to project interventions and those who had not been exposed.

A consistent theme of the evaluation was that the comprehensive approach taken by Dialogue Project, rather than just a focus on commodity provision, was appreciated by beneficiaries and was a major factor for them to make the decision to be involved with the program. This approach towards vulnerable populations' needs contributed to increase of vulnerable populations' coverage with outreach prevention services, behavioral risk reduction, HIV and TB services, and TB case detection improvement. Vulnerable populations are more eager to listen about HIV and TB prevention and treatment when their other needs are met.

Due to the structural and cultural barriers faced by civil society in general and vulnerable populations in particular in Central Asia, many of the Dialogue Project implementing partners were not community based organizations run and managed by vulnerable populations (although there were exceptions to this in all three countries), even though all had vulnerable populations working as outreach workers and project coordinators. The net effect of this was that in general vulnerable populations were treated purely as passive beneficiaries of projects not as active participants in the design and implementation of project activities. Without more active participation there will not be community ownership of the project, which will have an impact on long term sustainability and ownership of both the NGO providing the services and the continuation of activities beyond the life of the Dialogue Project.

**Recommendation 5.1:** The Dialogue Project should (1) revisit the Greater Involvement of PLHIV (GIPA) model and determine how to more effectively create community ownership over the project and (2) strengthen its governance by ensuring that all vulnerable populations are represented on the regional oversight committee and in country working groups.

**Recommendation 5.2:** For PWID and PLHIV, more outreach work needs to be done with sexual partners to prevent sexual transmission of HIV and educate about TB.

Stigma and discrimination continue on the part of health care providers, particularly at TB dispensaries and primary health care facilities. The project should intensify work to reduce stigma and discrimination at these locations in order to better meet the HIV and TB needs of vulnerable populations.

A greater focus on gender is needed. Interviews with NGO leaders and their staff indicate that the Dialogue Project has not provided orientation with regard to the gender-specific needs of vulnerable populations.

## **PWID**

The Break the Cycle model appears to be meeting the needs of PWID in terms of harm reduction to prevent HIV transmission. Overdose treatment through distribution of Naloxone is valued by the clients and is seen as a positive motivating factor to participate in project activities.

**Recommendation 5.3:** Referrals to drug treatment services need to be more strongly linked to the outreach model and the barriers to treatment (cost and lack of anonymity) need to be addressed.

**Recommendation 5.4:** Health care services that are not available now (such as abscess and vein care and dentistry) need to be provided to vulnerable populations.

**Recommendation 5.5:** The project needs to strengthen the sexual prevention component for PWID. Currently neither implementers nor beneficiaries consider this to be important.

**Recommendation 5.5:** Improving service provision for female PWID, including reproductive health and

family planning services.

### **Sex workers**

The Adara model meets most of the needs of sex workers. But gaps exist, including inability of sex workers to pay for STI treatment once diagnosed. There is still a great need to effectively address police harassment of both sex workers and outreach workers, which occurred to a varying degree across the three countries. In addition, providing services and outreach to sex workers at appropriate times was a problem; in the evenings when most sex workers were working, it was difficult to conduct outreach without scaring clients away, and during the day, the sex workers were either sleeping or had children to look after, making it difficult to conduct workshops or sessions. The drop in center model helped somewhat to alleviate this, but drop in center opening hours were limited due to resource constraints. In Kazakhstan, for example, the project has attempted mobile VCT services, which increased the proportion of sex workers tested for HIV. When the mobile service for VCT was discontinued, testing decreased. This suggests that mobile VCT is a more effective way to reach sex workers than exclusively through referrals. In addition, sex workers have unmet needs with regard to family planning and reproductive health services and acquiring registration documents.

**Recommendation 5.6:** More effectively addressing police harassment and gender based violence.

**Recommendation 5.7:** Revisiting drop in center and outreach worker hours to better fit in with the lifestyle of sex workers.

**Recommendation 5.8:** Revisiting mobile VCT as an outreach methodology

**Recommendation 5.9:** Incorporate sexual/reproductive health and family planning into the Adara model.

### **MSM**

The LaSky model is considered to be effective by those interviewed, particularly for young MSM. The voucher system for referrals is appreciated by clients, since it allows them to receive services anonymously and without documentation. However, MSM do not have strong health-seeking behavior and motivating them to use services is a continuing project challenge. Not all of the LaSky model's components (found in the original Russian model) have been implemented by the project due to cost limitations. According to those interviewed, the Dialogue Project's model does not employ enough promotional and motivational materials. Also, the LaSky branding is mixed with the project branding (traffic light sign), which is considered by the beneficiaries to be irrelevant to gay culture.

The LaSky model emphasizes condom use for all sex and does not differentiate between oral and anal sex, nor passive/receptive roles and the HIV risk attached to these activities. The result of this is that discussions regarding sex with MSM come from a "disease centered" approach which says that sex results in disease (HIV and STIs) therefore all sex is risky, rather than a "sex positive" approach that comes from the view point that sex is pleasurable and that some sex requires condom use and some doesn't. Coupled with this is a complete lack of addressing the needs of MSM PLHIV and their right to have sex.

**Recommendation 5.10:** The LaSky model should be revised to ensure it is sex positive and addresses the needs of MSM PLHIV.

The evaluation team also has some concerns about whether the project consortium is prepared to advocate for the needs of MSM. Some participants of the Dialogue Consortium demonstrated skeptical attitudes when discussing the results of HIV rapid tests among MSM that found significant HIV prevalence among MSM. “This survey was not approved by Rep AIDS Center” and “these were only express tests that are not reliable” were comments heard when discussing prevalence among MSM with the project consortium team. The most skeptical attitudes came from the Kazak Association of PLHA. These attitudes could mean that MSM are not represented in the Dialogue Project, and that the needs of HIV-positive MSM are not advocated for through the existing advocacy tools.

### **Prisoners**

The START Plus model is meeting the needs of inmates and former prisoners. The model appears to be most effective while the clients are in prison, with varying degrees of success when they leave, depending on the presence of a strong referral and support network (as exists in Kyrgyzstan). While in prison, needles/syringes are available in some locations; condoms, although available, are limited. According to those interviewed, prisoners very much value project activities while they are in prison. However, beneficiaries of this model have very basic needs upon release from prison. Often project social workers/outreach workers are the only ones upon whom they can rely. Their needs range from documentation, housing, employment, and clothing, to soap and a shower. While the Dialogue Project cannot provide all of the support prisoners need upon release from prison, more effort is needed to connect NGOs working with former prisoners and other vulnerable populations (particularly PWID) in a network so that a strong referral system for additional services is in place for inmates upon their release. In addition, overdose prevention through distribution of naloxone should be included in the model.

### **PLHIV**

The UNISON model has been successful and has made a significant structural change into how the TB and HIV testing, treatment and social/support needs of PLWH are met. However, the model needs stronger integration of MAT, a topic that is still sensitive, particularly in Kazakhstan. Narcologists work for MDTs only at sites where MAT is available which limits the effectiveness of the service.

**Recommendation 5.11:** In order to address these needs, there is a need for more integration of HIV, TB, and MAT services. MAT should be available in all TB facilities. Also ARV and TB treatment should be available in MAT programs on a one-stop shop basis.

MSM PLHIV is an underserved subgroup of PLWHA due to stigma and discrimination amongst PLHIV groups and implementing NGO’s.

## **6. How effectively has the project addressed the integration of HIV/ TB/ drug treatment? (Goal 3, 4)**

The Dialogue Project was the first project to systematically address the issue of HIV and TB services integration in Central Asia. One of the project’s main achievements is that TB issue for vulnerable populations was considered.

In order to succeed, the Dialogue Project implemented numerous advocacy activities, built partnerships, and impelled structural changes to health care systems in the region. However, the process of integration is far from being completed.

In the area of prevention, TB services were included in outreach work to vulnerable populations by HIV-service NGOs. In this way, existing networks of NGOs were successfully used to reach vulnerable populations with interventions designed to improve knowledge of TB. What is more, vulnerable populations received access to TB tests and referrals to TB treatment. Voucher referral system and escorts were used for these purposes. In the opinion of the implementing partners, this approach led to increased TB case detection among vulnerable populations.

However, despite the fact that TB control is crucial among vulnerable populations, up to this moment this achievement is not sustainable. Outreach work among these groups is mostly oriented to HIV prevention. This work is implemented by networks of NGOs and supported by international donors, predominantly the Global Fund. At the same time, national TB programs target only the general population, and are realized within national health care systems. Up to now, there is no serious cooperation between national TB and HIV programs. As Dialogue Project management explained, they present concerns about TB programs at CCMs meetings and round tables. However, if the situation is not changed by the end of the project, only PLHIV, including prisoners and PLWHA will have the same access to TB services within the framework of MDT work (UNISON model). There are also no additional plans for TB control activities targeted to sex workers and MSM, since it is not considered a donor priority. Nevertheless, the Dialogue Project evaluation in Kyrgyzstan discovered that the demand for TB services is high among these vulnerable populations. There are many sex workers and MSM migrants, as well as MSM former prisoners who have higher risks of TB exposure.

**Recommendation 6.1:** Intensify advocacy efforts to integrate TB control activities into HIV prevention programs for all vulnerable populations, including sex workers and MSM.

**Recommendation 6.2:** Advocate for cooperation between national TB and HIV programs, including elaboration of integration strategies, and seek state approval of these documents.

**Recommendation 6.3:** Draw more attention at Regional Oversight Committee and CCM meetings to the issue of cooperation between national HIV and TB programs.

Another important point of integration is the availability of VCT in TB facilities and primary health care centers. Currently, HIV testing is theoretically available in TB facilities and primary health care centers. However, the quality of counseling is in question. In Kazakhstan, HIV blood testing is available in TB facilities and primary health care centers but counseling is provided in rare cases. In Kyrgyzstan, HIV testing and counseling are available in TB facilities and primary health care centers (FMCs – Family Medical Centers). However, it is worthy to note that in these centers, these activities are just being started and scale up is still in progress. The data on TB patients who went through HIV testing is sent to the Republican medico-informative center annually. In Tajikistan, both HIV blood testing and counseling are available in TB facilities, while none of these services are available in primary health care centers.

Dialogue efforts to address the issue included introducing a session on VCT in the training manuals for health care providers, and trainings for health care providers. In Kyrgyzstan, relevant activities were supported by the Global Fund, which provided financial support for VCT specialists. In cooperation with the USAID Central Asia TB Project, the Dialogue Project also organizes joint mobile VCT to the places where vulnerable populations gather.

**Recommendation 6.4:** Explore and address reasons why the high quality counseling component of VCT is not still available in targeted TB facilities and primary health care centers. Consider analysis of success stories at selected sites and the applicability of their experience to scale up.

In the area of treatment, there was an integration of TB and HIV services for PLHIV in the work under the UNISON model. Integration was supported by voucher referral system like elsewhere.

Numerous successful outcomes were gained from Dialogue Project activities on this component.

First, people with HIV/TB co-infection received access to comprehensive diagnostics and treatment services. With the introduction of MDT (UNISON Model) in Kazakhstan, the time needed to diagnose TB was reduced from between 3 to 4 months to 1.5 months. For PLHIV, this increased the accessibility of TB treatment. In Kyrgyzstan, AIDS Centers and TB dispensaries were reluctant to take responsibility for patients with HIV/TB coinfection and redirected them from one to another. The Dialogue Project addressed the issue in round tables with health care authorities and providers, resulting in MOH orders on HIV and TB services cooperation. Now patients with coinfection receive treatment in accordance to relevant clinical protocols.

Second, necessary staff changes were addressed. TB specialist and social workers job openings were opened up in Kazakh City AIDS Centers. In Kyrgyz, cooperation between HIV and TB specialists in primary health care centers was established in terms of MDT work with support from NGOs' outreach and social workers. However, the problem of shortages of health care providers and their low wages is common in the entire region and places obstacles to achieving program goals.

Third, treatment adherence was increased with the help of outreach workers, who provided clients with social support, escort, and case management. This was an important part of the Dialogue Project's contribution to solving the problem of adherence to treatment for people with multiple diagnoses.

However, there is an integration gap because of the vertical and centralized health care systems in the region. The full circle of TB diagnostics and TB treatment can be provided only in TB facilities staffed with TB specialists. Smear positive TB patients can be treated only in TB facilities on an in-patient basis.

The situation is similar for HIV diagnostics and treatment. The full circle of HIV diagnostics and ARV treatment are possible only in AIDS Centers. In this way, the system complicates diagnostics and treatment of people with HIV/TB coinfection. The Dialogue Project addressed this gap introducing escorting, and case management by MDTs' outreach workers, who help clients to receive services in both HIV and TB institutions. However, the most effective results would be achieved if patients were able to receive services on a one-stop shop basis. It is worthwhile to note that some decentralization in AIDS care is happening in Kyrgyzstan, where AIDS Centers have started to delegate their responsibilities on ARV prescription to primary health care centers.

It must be also noted that out-patient TB treatment and prevention with isoniazid courses are available for PLWHA in AIDS Centers (or in primary health care centers in Kyrgyzstan). The same is true for ARV-treatment, once it is prescribed, PLWHA can receive their medication in the TB dispensary.

In the opinion of project implementers, health care providers, and stakeholders (GF PIU) in Kazakhstan, the most problematic TB issue for vulnerable populations is a full circle of diagnostics before TB treatment prescription. At the same time, the country does not experience TB treatment stock-outs; therefore, there are no serious concerns about treatment.

In Kyrgyzstan, concerns are about availability of treatment. Currently there is a stock-out of MDR TB treatment. MDR TB patients are not accepted in any TB facilities. There are no separate facilities for MDR TB patients.

In both Kazakhstan and Kyrgyzstan, there is a problem of access to free TB treatment for people without ID and registration. In Kazakhstan, foreigners do not have access to free ARV treatment.

**Recommendation 6.5:** Advocate further integration of TB and HIV diagnostics and treatment, setting universal access and provision of services on a one-stop shop basis as a strategic goal.

The integration of TB and HIV treatment for the PWID group has its own challenges. TB and ARV adherence is problematic without the integration of MAT services into TB/HIV treatment programs. At this point, progress is quite different for every country. Until very recently, Kazakhstan had only three pilot MAT sites serving less than 100 clients in total. However, the situation has now changed with the approval of opening of seven additional sites by the Ministry of Health. In sites where MAT programs are available, like Temirtau, MDT includes a narcologist who refers PWID to the MAT program at the local drug treatment facility. However, further questions of MAT integration into AIDS Centers and TB dispensaries were considered as currently premature (based on information from the meeting with PSI Kazakhstan). However, simultaneous MAT scale up together with integration of TB and HIV services could have its advantages. Firstly, in those countries where there is a resistance to MAT, this approach could provide decision makers with important pro-arguments, since MAT is a powerful tool for epidemic control. And second, it may appear to be easier to have the integration process already at the beginning of MAT scale up, in comparison to introduction new changes on MAT sites that have already been established. In Kyrgyzstan, MAT is widely available in drug treatment /narcological/ dispensaries and is also available in three TB dispensaries. However, there is a need to introduce MAT to all TB dispensaries in the country, as well as to introduce TB and HIV services into existing MAT programs. In Tajikistan, MAT is only available at three pilot projects in specialized state-run drug treatment dispensaries (Dushanbe, Khudjand, and Khorog) and is not available in TB facilities, AIDS Centers, or primary health care centers.

**Recommendation 6.6:** In cooperation with all relevant stakeholders, advocate for introduction MAT to those AIDS Centers, TB facilities, and primary health care centers, where it is not yet available.

**Recommendation 6.7:** In cooperation with all relevant stakeholders, advocate for introduction TB and HIV services into already existing MAT programs to provide services on a one stop shop basis.

**Recommendation 6.8:** Advocate for MAT scale up simultaneously with integration of TB and HIV services.

In the programmatic component of better data being used for decision making, HIV/TB integration was also addressed. First of all, the Dialogue Project's MIS and TRaC include TB indicators. If the responsibility for MIS is passed to national states, TB indicators are already in place. If the Dialogue Project succeeds in the institutionalization of voucher referral system, then states will receive statistics on TB cases among vulnerable populations through the MIS. Secondly, in both Kazakhstan and Kyrgyzstan, the Dialogue Project Consortium successfully advocated for inclusion of TB indicators into national HIV surveillance among vulnerable populations. For the moment, there are no other relevant surveillances on TB in the region. However, the inclusion of TB indicators in HIV surveillance may not be sustainable in Kazakhstan, where there is an ongoing debate to exclude TB indicators, since the questionnaires are too big.

**Recommendation 6.9:** Advocate for further institutionalization of voucher referral system and MIS adoption by government, contributing to the availability of strategic information on TB/HIV among vulnerable populations for national decision makers.

**Recommendation 6.10:** Assess the information value of having TB indicators included in the national HIV surveillances, and if they are of value, the Dialogue Project should advocate for their continuation.

## **7. How effectively has the project used data to monitor its performance and guide implementation?**

Overall, both annual and quarterly performance reports contain very extensive and high quality information on the implementation of the project in respective countries including the key challenges faced by the partners. Similarly, proposed yearly implementation plans contain country-specific outline of activities to be carried out during the upcoming period. TRaC studies include both key and extensive recommendations that are developed to inform and guide implementation. Finally, all implementing partners have been provided with and trained in the use of database /program MIS/.

The evaluation team compared the narrative and study reports vis-à-vis field observations and examined earlier reports in relations to progress reported in subsequent ones.

While in general the implementation of the project in Kazakhstan, Kyrgyzstan, and Tajikistan followed the implementation plans, in each of the countries there were few challenges that have either been left unaddressed or have not been followed to the full extent, often due to political/structural obstacles in place. In Tajikistan, for example, there is an apparent lack of advocacy activities for expansion of opioid substitution therapy (OST) to the Khatlon region (Kulob and Qurghonteppa), which, as the team understands, is linked with high sensitivity of this issue in that region. At the same time, the Dialogue Project's Year Three, Quarter Two Performance Report identifies the increased demand for MAT in Tajikistan as a key finding and emphasizes that elsewhere in Tajikistan, "the program has limited space and is not able to enroll all PWID who would want to be referred" by the Dialogue Project.<sup>23</sup>

The evaluation team also noticed a lack of strong and consistent connection between the recommendations from TRaC surveys and information and education materials provided by the Dialogue Project to its beneficiaries.<sup>24</sup> As observed by the team during its visit to Kazakhstan, Kyrgyzstan, and Tajikistan, the majority of information and education materials that were currently available were developed through funding from the Global Fund and other partners, such as AFEW. These materials were not necessarily informed by data generated through TRaCs, and may not have followed the recommendations of the surveys. However, according to interviews in Kazakhstan, Kyrgyzstan and Tajikistan, TRaC survey recommendations are integrated into the content of sessions/messages that are communicated to the clients by implementing partners (outreach and social workers) through verbal interpersonal communication.

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<sup>23</sup> USAID Dialogue on HIV and TB Project, Quarterly Performance Report, Year Three, Quarter Two, USAID Cooperative Agreement No. No. 176-A-00-09-00023-00, January 1 to March 31, 2012, p. 41.

<sup>24</sup> Central Asia Republics. (2010). HIV and TB TRaC study evaluating risk behaviors associated with HIV transmission and utilization of HIV prevention and HIV/TB co-infection prevention among IDUs in Almaty, Karaganda, Osh, Chu, and Dushanbe. First Round. PSI Research Division; Kazakhstan, Kyrgyzstan, Tajikistan. (2010). HIV and TB TRaC study among men who have sex with men in Almaty, Bishkek, Chui, and Dushanbe. Round 1. PSI Research Division; Central Asia Republics. (2010). HIV and TB TRaC study evaluating risk behaviors associated with HIV transmission and utilization of HIV prevention services and HIV/TB co-infection prevention among sex workers in Karaganda and Almaty (Kazakhstan), Chui Oblast (Kyrgyzstan), Dushanbe, Vahdat District, Kurgan-tube, Kulyab (Tajikistan). First Round. PSI Research Division.

**Recommendation 7.1:** TRaC survey recommendations continue to be incorporated into sessions content and information and education materials and closely monitored by the Consortium members.

In order to track the incorporation of recommendations from TRaC surveys into project materials (modules, IEC materials, etc.) and their actual implementation, the evaluation team compared MSM 2010 TRaC survey recommendations with available data sources and field observations. The results of this exercise are presented in Table 11 below, suggesting that many of the recommendations were fulfilled either completely or partially.

**Table 11. Analysis of MSM recommendations from TRaC surveys in 2010**

<i>Recommendations from research findings (TRaC)<sup>25</sup></i>	<i>Incorporation (annual plans, PMP)</i>	<i>Implementation (annual &amp; quarterly reports, interviews, focus group discussions, IEC materials)</i>		
		Kazakhstan	Kyrgyzstan	Tajikistan
Tailor different services to MSM with particular characteristics	No	No	Yes*	Yes, partially
Younger MSM should be targeted.	Yes	Partially	Yes	Yes, partially
Organize sessions on the “VCT experience” that provide an opportunity for MSM who have been tested to share their experiences with those who have not been tested	No	No	No	No
Encourage MSM to encourage their partners to get tested for HIV	No - in plans, Yes - in training modules	Yes	Yes	Yes
Conduct activities to spread the following messages: (1) That any partner – no matter how trustworthy – could have HIV; (2) that you can protect yourself and your partner by using condoms; and (3) that you are personally at risk for being infected with HIV if you have had sex even once without a condom	Yes	Yes	Yes	Yes

<sup>25</sup> Kazakhstan, Kyrgyzstan, Tajikistan. (2010). HIV and TB TRaC study among men who have sex with men in Almaty, Bishkek, Chui, and Dushanbe. Round 1. PSI Research Division; Central Asia Republics.

Work on negotiation skills for convincing sexual partners to use condoms and saying no	No - in plans, Yes - in training modules	Yes	Yes	Yes, in training modules); not enough evidence to know (IEC materials)
Distribute IEC materials that correspond to the key message(s)	Yes	Yes**	Yes	The team was unable to verify this due to renovation works at NGO Legal Support
Rotate key messages each quarter for mini-sessions, long-format sessions, and edutainment events.	No - in plans, Yes - in training modules	Yes	Yes	Yes
Create more than one activity per priority determinant for long-format sessions and mini-sessions.	No - in plans, Yes - in training modules	Yes	Yes	Yes
Communicate all messages in a clear, concise, and simple manner	No - in plans, Yes - in training modules	Yes	Yes	Yes
TB: Raise knowledge, Reduce stigma	Yes – at the beginning, No – at the time of evaluation***	Yes, occasionally, based on a request of the client	Yes	Yes

\*Services were tailored to cover different subgroups of MSM:

- 'Flame boys' – young club visitors
- Ex-prisoners and MSM from rural areas
- Older and most hidden MSM from the upper strata of society.

Subgroups have their separate self-help groups, trainings, and peer counselors.

\*\* IEC arrived by the end of the project

\*\*\* At USAID's suggestion, MSM were not considered to be a key group for TB component. Evaluation in Kazakhstan found that MSM group was not interested in TB information and testing. However, in Kyrgyzstan, the demand for TB services was higher among MSM, since there were migrants and ex-prisoners among them. Due to the efforts of outreach workers, all their clients received mini sessions on TB.

**Recommendation 7.2:** Conduct exercises to compare the integration of research findings into practice on a regular basis and implement this analysis for all vulnerable population groups.

As for the MIS, the Dialogue Project has effectively used MIS data to monitor its performance and guide implementation. NGOs entered data to MIS from their paper back-up. All these data were aggregated in respective PSI country offices, and PSI followed up the progress of every implementing partner and made necessary managerial decisions.

A good example of how data has been used occurred in PY3 in Kazakhstan, when the project detected that the number of referrals slightly decreased. According to the project's PY3 Annual Performance Report, meetings were held with sub-awarded NGO program staff to find out the causes of referral

decline during which it was revealed that fewer clients were referred because they were previously tested for HIV and TB in the previous 12 months. As suggested in the report, “some were tested in prison, others were tested when being treated for drug dependence, and there were those who participated in HIV sentinel surveillance studies and were tested.” Thus, to track the trend in referrals to HIV and TB testing services project staff detected a need to update the MIS to track if clients have received testing services in the previous 12 months and, therefore, were not referred by outreach workers.<sup>26</sup> Another good example comes from Tajikistan, where after series of cross-partner study visits, PSI organized coordination meetings to discuss follow up actions. Minutes of such meetings were then effectively used to track the implementation of recommended actions.

Finally, the project has generated a considerable amount of data through the MIS, TRaC and most recently with FoQus. However, comparative data over time to measure progress toward reaching project goals is scanty, since much of this data is planned to be obtained at the end of the project. With the exception of MSM, for which a TRaC was conducted in 2012, relatively little is known about the change in behavior and service utilizations among other vulnerable populations, particularly sex workers and PWID. Had TRaCs for sex workers and PWID been conducted in PY3 that could have then been compared to PY1, the project would have had access to good data, at mid-project, for fine-tuning of project interventions, as it currently has for MSM (the evaluation team recognizes that, at the request of USAID, small-scale, stand-alone TRaCs were conducted in 2012 to provide a “snapshot” into the population, which was not intended to be compared with 2010 baseline data).

**Recommendation 7.3:** Whenever possible, collect comparative data and measure changes over time.

## **8. Has the project’s cross-regional consortium structure and division of technical responsibilities contributed to the achievement of results?**

The consortium structure has contributed to the achievement of results. Most notably, it has led to:

- A unified voucher/referral system implemented in all project sites
- A common understanding and implementation of project models
- Cross-project learning resulting in project innovation

A unified, regionally coordinated project strategy has meant that the Dialogue Project has been able to achieve project goals and provide a platform for sharing lessons learned and best practices.

A regional oversight committee and country working groups oversee project implementation. These groups review project progress, provide expert advice, share results and lessons learned across the region, and work to strengthen the regions strategic response to HIV and TB.

PSI serves as the prime recipient and administrative secretariat, overseeing partners and serving as the primary contact for USAID.

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<sup>26</sup> USAID Dialogue on HIV and TB Project Annual Performance Report: Year Three. USAID Cooperative Agreement No. 176-A-00-09-00023-00. October 1, 2011 to September 30, 2012, p. 36.

Regional management takes place out of the PSI/Kazakhstan office, which is responsible for: financial and programmatic oversight; coordination of regional communication and information sharing; coordination and provision of technical assistance for program research and monitoring and evaluation; provision of technical assistance to partners in community-based outreach; reporting to USAID; and management of project partners at the regional level.

At the country level, a designated country coordinating organization is responsible for: country-level programmatic oversight; coordination of country-level partners and stakeholders, including coordination of country working groups; country reporting; and communication with USAID country offices. PSI is the coordinating organization in Kazakhstan, Kyrgyzstan and Tajikistan while Project HOPE is the coordinating organization for Uzbekistan and IFRC for Turkmenistan. All local NGO sub-awards flow through the respective country level coordinating organizations that provide supervision and quality control.

Consistent feedback from across the three countries visited, from both project partners and implementers, noted that the regional consortium model was helpful to the program. In particular, it enabled the development of the referral and voucher system at the regional level by creating a standard system for all countries to implement and garnering support from GFTAM, UNAIDS and others, and at the country level, by supporting the agreement of Republican AIDS Centers, Ministry of Health and the Global Fund to accept and implement the voucher/referral system.

One issue to consider is the movement of people across the region and whether there is scope for a cross-country acceptance of vouchers. For example, clients in cross border areas could use a voucher from one country to access services in another country.

**Recommendation 8.1:** Cross country acceptance of vouchers be investigated

The regional consortium helped develop a cohesive approach to understanding and implementing project models. All implementing agencies, outreach workers, and other workers/volunteers were appreciative of the trainings provided to help them understand and implement the project models. The Break the Cycle (BTC) model in particular is complex, with a range of variables that make implementation difficult, but the project's regional approach provided the opportunity for implementers to fully understand the model and apply it in their local settings. This meant that the BTC model (and others) was consistently applied across the program, creating a truly regional approach.

Cross project learning resulting in project innovation. Dialogue has provided a number of opportunities for intra-country and intra-regional exchanges as well as regionally based training and capacity building. These have been offered by the project itself and also by the QUALITY project, which complements the technical capacity building of the Dialogue Project with organizational capacity building. These opportunities have been appreciated by participants and direct program improvements and innovations can be seen. For example "Legal Support" NGO in Dushanbe has been able to incorporate internet based outreach into its MSM LaSky project based on training received and "Plus Center" NGO in Osh was assisted with strategic planning by the QUALITY Project.

In 2011, a series of trainings for community leaders on community involvement and mobilization were conducted in project sites for 399 community leaders. These trainings were part of the process to address long term sustainability of the project beyond USAID and Dialogue Project support. In addition, and as a result of requests from implementers from all countries, case management trainings to

strengthen the community assisted treatment adherence support component were implemented during PY3. More attention to providing case managers with on-site monitoring and feedback for improvement was made.

An analysis of regional trainings and meetings has shown that the Dialogue Project has held 10 regional / cross project trainings. These trainings are directly reflected in the annual work plan and respond to needs identified through the TRaC surveys and for BTC, LaSky and Adara models. See Table 12.

**Table 12. Overview of trainings conducted during the Dialogue Project**

<b>Training/Meeting</b>	<b>Country</b>	<b>Date</b>
Regional TOT on “LA Sky- Trusting Each Other” model for MSM	Bishkek, Kyrgyzstan (by PSI)	March 25-27, 2010
Regional TOT for MDT	Dushanbe, Tajikistan (by AFEW)	April 26-29, 2010
Year One Regional Oversight Committee and Program Launch	Almaty, Kazakhstan	April 15-16, 2010
Regional IEC Material Development	Dushanbe Tajikistan (by PHOPE)	May 3-5, 2010
Regional Year 2 Strategic Planning Retreat	Kazakhstan	August 11-14, 2011
Year Two Regional Oversight Committee	Almaty, Kazakhstan	January 20, 2011
Regional Workshop of USAID Dialogue on HIV and TB Project 9 MDT teams	Almaty, Kazakhstan	June 27-28, 2011
Regional Meeting for Midterm Project Performance Results	Almaty, Kazakhstan	December 23, 2011
Regional Orientation Meeting for Sub-awarded organization (IOM) to implement the Project among migrants	Almaty, Kazakhstan	June 19-21, 2012
Regional MDT Forum	Almaty, Kazakhstan	July 5, 2012

## **9. How well has the project coordinated with other donors and projects working with vulnerable populations, and has existing coordination resulted in accelerated progress towards project goals and mission strategic objectives?**

Dialogue coordinates well with other donors and projects, this has led to complementary programming with little overlap or duplication of effort, however work still needs to be done to ensure program models are consistent across different donors and programs.

The Dialogue Consortium partners participate in HIV and TB Country Working Groups/ Technical Working Groups in each project country. These working groups meet to provide the project with the opportunity to promote the goals and approaches of the project, share results and experiences and to seek support for project components and recommendations for overcoming obstacles to implementation faced in the respective countries.

Regular partner meetings are conducted with other key healthcare projects implemented in the region, including the USAID Quality Health Care Project, CDC Support Project, Global Fund-supported and other donor projects.

PEPFAR joint work planning meetings are conducted in Kazakhstan, Kyrgyzstan, and Tajikistan to harmonize PEPFAR partners' activities. Representatives from USAID and USAID project implementing partners, CDC, Republican AIDS Center and the MOH attended these meetings.

Joint monitoring visits are carried out by the Dialogue Project and the Global Fund in Kazakhstan.

With a limited number of implementing NGOs, multiple donors are often working with the same NGO; while this results in a broader funding base for implementers, it has resulted in multiple reporting systems and project modalities being developed. In general Dialogue Project models are more comprehensive and quality focused than those of the Global Fund, which are more geared towards commodity distribution. This can mean the depth of services offered by the NGO to a client can vary; depending on whether the activity is Dialogue, Global Fund (or other) funded, resulting in inconsistency. Similarly if a Dialogue Project activity is "handed over" to the Global Fund, modalities can change, resulting in a different program model being delivered. The regional cooperation mechanisms in place should be used to help alleviate some of these discrepancies.

**Recommendation 9.1:** Regional cooperation mechanisms address discrepancies in project modalities, particularly in the case of "hand over" and that simplified reporting systems are developed that can apply across donors.

## **10. To what extent are project models and results sustainable?**

Project models and results appear to be partially sustainable, with some of the models and approaches having already been adopted by the national authorities. Referral and voucher system is functioning very well in Kazakhstan, Kyrgyzstan and Tajikistan. Over the past three years, implementing partners have gained substantial experience in implementing Dialogue Project models, and the implementation of the UNISON multidisciplinary approach to treatment adherence among PLHIV Model has led to a considerable improvement in care of PLHIV. Furthermore, implementing partners improved their capacities in outreach, case management and data management, and are now better positioned to compete for funding. However, major obstacles to the sustainability of project models and results remain in place in all three countries. Without sustained funding base, the sustainability of the majority of implementing partners as well as of the services they provide will be significantly undermined. Similarly, referral and voucher systems can become fully sustainable only if voucher-entitled services are supported financially. Despite the fact that a significant number of trainings has already been provided to implementing partners, there is still room for improvement of the quality of services and more capacity building is needed to better position Dialogue Project partners to succeed following the completion of the project.

A detailed analysis of identified project- and country-specific challenges to sustainability of project models and results, as well as the recommendations to address them are provided below.

## *Financial*

In Tajikistan and Kyrgyzstan, the key issue in terms of sustainability of project models and results relates to the inability of the government to take over the funding of the Dialogue Project supported network of partners and services once the project is completed. At all meetings in Tajikistan and Kyrgyzstan, partners stressed that the prospect of state funding of harm reduction services was out of the question in the foreseeable future. Currently, VCT is being funded through the Global Fund grants, although in the recent past there was a shortage of tests and the Tajik Republican AIDS Centre was unable to provide VCT to all Dialogue Project referred clients. Similarly, TB films were donated to Tajik national TB facilities by Project HOPE. Against this backdrop, the Ministry of Health of Tajikistan issued a decree (Ref #600) that authorized the transition to a fee-based health care system, with vulnerable populations ineligible for free testing and care services in most of the cases. This primarily concerns STI and TB testing and diagnosing (for example, in the evaluation team's conversation with sex workers in Dushanbe, they lamented the lack of access to free STI treatment). Furthermore, another issue faced by the Tajik NGOs since late 2011 was related to the requirement of the State National Agency for Pharmaceutical Goods Control to obtain a pharmaceutical activities license for distribution of HIV and overdose prevention commodities (needles and syringes, naloxone and other medical supplies). Although the Agency subsequently agreed to suspend the enforcement of that requirement at least until the end of 2012, with such structural obstacles in place, at the end of the project vulnerable populations would not be able to receive most of the testing and care services for free, while the classification of needle and syringe distribution among vulnerable populations as a 'pharmaceutical activity' will considerably increase the cost of harm reduction services. This will significantly affect the sustainability of these services. At some meetings with implementing partners in Tajikistan, these partners discussed the engagement in some sort of income-generating activities as a sustainable way to support their harm reduction and HIV prevention programs.

The situation in Kazakhstan is different in terms of funding, with the Kazakh Government procuring the majority of needles and syringes for NSPs, as well as ARV medications, and making funding available for NGOs on a competitive basis (through the "*sotsial'nyi goszakaz*" – social state order of services). At the moment the Government of Kazakhstan does not have a special program on countering HIV/AIDS. Instead, there is a public health development program, and the national HIV response is part of this program. When/if the new program is adopted, then there might be more state funding dedicated specifically to HIV prevention, and NGOs working with vulnerable populations might get more funding from the government. Meanwhile, the Kazakh Ministry of Health has recently announced a call for applications for the best public health project, and any NGO can submit their applications. However, one of main problems with the "goszakaz" system in Kazakhstan is that HIV prevention through sexual transmission and harm reduction activities (among MSM and sex workers in particular) are usually not seen as priority activities and, consequently, most of the funding made through the "goszakaz" goes to other areas such as education, environment etc. With the international donor funding fading away in Kazakhstan, and support from the Global Fund considerably decreasing, the prospects of sustaining HIV prevention efforts (especially among MSM and sex workers) in Kazakhstan may appear rather gloomy.

**Recommendation 10.1:** Consider providing support and training to build NGO capacities for raising funds for and implementing income-generating activities as an additional way to ensure greater sustainability of the Dialogue Project results, especially in Tajikistan and Kyrgyzstan.

**Recommendation 10.2:** In Kazakhstan, it is essential for NGO capacity be built for project proposal development to successfully compete for state funding. Part of this need is to be able to demonstrate to the government all the good results that NGOs are achieving through the Dialogue Project.

**Recommendation 10.3:** In Kazakhstan, sensitizing national and local governments to the importance of having vulnerable populations-targeted funding and projects is also one of the key sustainability and advocacy priorities. This can be achieved by the inclusion of the Dialogue Project-supported NGOs into the project’s coordination structure and into budget planning mechanisms that are responsible for budget planning for social services provision.

**Recommendation 10.4:** In Tajikistan, advocate for the inclusion of vulnerable populations in the list of groups of population eligible for free testing and treatment at state health care facilities.

**Recommendation 10.5:** In Tajikistan, work together with other partners to advocate for a significant mitigation/elimination of the requirement for NGOs to obtain a pharmaceutical activities license for distribution of needles and syringes, naloxone and other harm reduction and HIV prevention materials.

### *Technical Models and Approaches*

At all meetings with implementing partners, they emphasized that the models used within the Dialogue Project were relevant and considered as best practices. In particular, the UNISON Multidisciplinary approach to treatment adherence among PLHIV was very highly praised in terms of considerably improving the care of PLHIV. All members of the MDTs suggested that the national and regional authorities were very happy with the contribution the MDTs were making to responding to HIV; as in the case of the Temirtau MDT, several local health facilities continued to rely on referrals through MDT even after the funding from the Dialogue Project was discontinued. In Kyrgyzstan, the MDT model is formally endorsed and incorporated into the health care system through clinical protocols on PLHIV treatment and care and through ministerial orders. In other countries, the status of MDTs is formalized too.

Furthermore, the inclusion of naloxone distribution and the provision of trainings on overdose prevention were highlighted as very important elements of the Dialogue Project activities focused on people who inject drugs (opiates).

While the complexities in measuring the effectiveness of the Break the Cycle (BTC) Model in preventing initiation of drug injection were well appreciated both by programmatic staff and outreach workers, the interviews that the evaluation team had in the three countries it visited suggest that this model was still appropriate and appealing to many clients. One of the key issues that the BTC model may find difficult to address, though, is that for many PWID, initiating others into injecting usually brings certain short-term ‘benefits’ (i.e., the newly initiated drug injector is normally expected to share his/her drugs with his/her ‘teacher’ at least for some time, while he/she does not run out of financial means). These immediate ‘benefits’ may outweigh arguments for not initiating others into drug injecting – something that the team consistently heard during interviews with clients and outreach workers.

The biggest issue for the prison component is its sustainability after January 2013, when the Dialogue Project finishes its work on this component. In Kyrgyzstan, AFEW is currently developing guidelines for comprehensive work with prison inmates on the basis of the START Plus model, which would then be passed to the national prison authorities for approval. Once approved, it is expected that the prison personnel (social workers and penal inspectors) will be responsible for social support and reintegration of prison inmates into society. This inevitably implies the necessity for prison administrations to secure state funding for covering additional costs related to the implementation of the guidelines, and it is not clear if the Kyrgyz Government can commit to such funding. In addition to this challenge, the status of a prison-based social worker is considered to be the lowest in the prison personnel hierarchy, with many penitentiary social workers either leaving their jobs or seeking promotion whenever such opportunities arise. Finally, when social workers are made part of the prison personnel, they are considered as part of

the ‘administration’, and for many prisoners any collaboration (including social) with the ‘administration’ is considered a taboo in accordance with the prisoners’ code of norms.

The Dialogue Project-introduced referral and voucher system was very highly praised by various stakeholders and project beneficiaries as well. In Kazakhstan, the project successfully advocated with regional health authorities to ensure that the voucher is recognized by regional health care administrations and health care providers and is incorporated into the existing referral and reporting system. In Kyrgyzstan, too, the referral and voucher system is a good example of positive structural change within the Kyrgyz health care system achieved by the Dialogue Project. The referral and voucher system provides a sustainable foundation for every model to provide vulnerable populations with accessible HIV and TB services within health care system in Kyrgyzstan. In Tajikistan, the Dialogue Project-developed voucher was recognized and used alongside the (far less elaborate) VCT voucher approved by the Tajik Republican AIDS Centre and the Ministry of Health and developed through financial support from the Global Fund. In the opinion of the evaluation team, using the Dialogue Project-developed voucher would be a better option for stakeholders in Tajikistan, because unlike the Global Fund voucher, it includes referrals to other services in addition to VCT, such as TB and STI services. Introducing a cross-country referral and voucher system can also serve as an opportunity to convince the Tajik health authorities to reconsider their stance on not having one unified referral and voucher system. The Regional Oversight Committee may need to be encouraged to play a particularly prominent role here.

Furthermore, the voucher itself is only a referral tool, while services provided to the holder of the voucher always need to be supported financially. Here the question of ‘who pays’ becomes a central one. Even in Kazakhstan, with the wealth of its resources, this question is problematic as the government is implementing a health financing model, which implies financial self-sustainability of primary health care facilities (polyclinics) and limited support from the national government. With this system in place, local municipalities are only covering the cost of services to people formally registered as residing in those municipalities (confirmed through “propiska” in their passports). Thus, according to colleagues of the Almaty City AIDS Centre, many PLHIV and other vulnerable populations who do not have their IDs with “propiska,” or who come from other regions within Kazakhstan (and other countries) are deemed ineligible for free TB and HIV care, which presents a threat to the sustainability of the voucher system. In Kyrgyzstan, this issue is also being seriously considered, and PSI and the Quality Health Care project are advocating for the allocation of 10% of health care budget to be used for medical services based on a voucher system. Successful pilot programs for allocation of funding based on the voucher system were already conducted in Kyrgyzstan. Finally, the ultimate institutionalization of the voucher-based referral system can be achieved when Ministries of Health take over the role of the agency responsible for issuing vouchers, distributing them to organizations working with vulnerable populations for further referral of vulnerable populations to service providers. Service providers would then be responsible for returning the vouchers back to the Ministries of Health, allowing for the collection and analysis of service utilization data and, possibly, for allocation of financial resources to service providers based on returned vouchers.

Other important components of the Dialogue project that have good prospects for sustainability include the Unique Identifier Code (UIC) and the Management Information System (MIS). The UIC was initially developed and introduced much earlier, through the USAID-funded Drug Demand Reduction Program, and therefore has a longer history of use and acceptance by national stakeholders in the region. As for MIS, while some implementing partners complained that the system still had some problems with the software, the Kazakh Republican AIDS Center GFATM PIU adopted the Dialogue Project-developed MIS

for use by its sub- and sub-sub-recipients throughout the country. In Kyrgyzstan, the Quality Health Care Project is working on the introduction of MIS to the Republican AIDS Center.

**Recommendation 10.6:** Consider the possibility of introducing of a cross-country referral and voucher system as one of the potential strategies to make services accessible to mobile groups of vulnerable populations.

**Recommendation 10.7:** Consider introducing some elements of Dialogue-developed training modules into the curricula of medical universities and/or institutions for continued education of health care professionals, to make them more sensitive to working with vulnerable populations.

**Recommendation 10.8:** Provide more training to end users of the MIS and make sure that all the remaining problems with the software are fully resolved as quickly as possible.

**Recommendation 10.9:** In Kazakhstan, identify different options and advocate for free HIV and TB care for PLHIV regardless of their local residency status.

**Recommendation 10.10:** In Tajikistan, continue the discussions with the Ministry of Health on the adoption of the Dialogue-developed voucher system.

### *Knowledge and Skills*

As described in the Cooperative Agreement, “building the capacity of community-based NGO partners to implement outreach” is vital for long-term sustainability and scale-up of program interventions.”<sup>27</sup> The evaluation team, however, felt that other activities (as described above) were equally vital for achieving long-term sustainability. Furthermore, focusing on outreach alone in terms of capacity building of NGO partners would be far from sufficient sustainability-wise. At meetings with implementing partners, they highlighted that burn-out prevention was badly needed to ensure the retention of staff (outreach and social workers in particular). Also, the team felt, on the basis of interviews with implementing partners, that in each country there was a need for more trainings to strengthen the knowledge and skills of implementing partners in delivering project services and interventions to the beneficiaries; this would improve the quality of services, making them more desired and, to some extent, increasing the prospects for sustainability after the project is completed (by making these services more attractive to funding). In Tajikistan, in particular, due to the known deficiencies in its post-civil war educational system, there is a stronger need for providing additional trainings to implementing partners in order to improve the quality of their services. In Kazakhstan, the MDT teams emphasized having a great need for more training, including trainings on adherence to ARV therapy and TB treatment. In all countries, there is also a need to pay more attention to specific needs of women in both trainings and in service provision. In addition, implementing partners would like to have their own sustainability road maps and need technical assistance from PSI on building these algorithms and necessary partnerships.

**Recommendation 10.11:** Assess each NGO’s needs for training and other technical assistance, and develop a road map of capacity building with specific activities to be undertaken in the remaining two years of the project’s implementation.

**Recommendation 10.12:** Develop sustainability road maps in partnership with implementing partners.

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<sup>27</sup> USAID Central Asian Republics, Cooperative Agreement No. 176-A-00-09-00023-00, p. 28.

## *Staffing*

In Kazakhstan, the Almaty City AIDS Center has a TB specialist position in its staffing structure; the position of a social worker has also been introduced, but the qualifications requirements include a university degree in social work, psychology or other related field, which almost none of the peer social workers have. In Tajikistan, one of the key vulnerabilities of the MDT model was also related to staffing, although here it was a severe shortage of trained medical personnel (TB specialists and Infectious disease specialists) that was considered as an obstacle to scaling up the UNISON Model and establishing new MDTs. For example, in conversations at SPIN Plus Drop-in Center, it was mentioned that the Republican AIDS Center has only a few qualified doctors who are extremely overloaded with the existing patient flow. Without financial incentives that are currently available to them through the Dialogue Project, it would be very challenging to retain those physicians in the MDTs.

**Recommendation 10.13:** In Kazakhstan, advocate for changes to social worker qualification requirements at health care facilities, in order to make sure that peer social workers are eligible to apply for these positions, since this is one of the top sustainability and advocacy priorities identified by the MDTs.

**Recommendation 10.14:** In those countries and AIDS Centers where the position of social worker is not included in the staffing structure, advocate for the inclusion of this position in the formal staffing structure.

**Recommendation 10.15:** Work together with the Ministries of Health to train more MDT medical specialists to strengthen the sustainability of MDTs in project countries.

## Summary of key issues to address for each of the principal evaluation questions

### 1. What is the logic or “theory of change” underpinning the interventions in the Dialogue Project? (Cross cutting issue)

Consider developing separate Logic models for each of the country components to reflect the priorities and issues facing each of the country programs.

### 2. How effective have project activities been in reaching various vulnerable population groups? (Goal 2)

Coverage targets need to be reviewed, to better reflect capacity of implementers to provide consistent quality services to both new and existing clients.

### 3. To what extent (quantity and quality) have specific interventions been effective in contributing to the achievement of planned results? (Goal 1, 2, 3, 4, 5)

- (1) Intensify interventions to prevent sexual transmission of HIV among PWID. (2) Identify and implement feasible interventions that can be undertaken in the last two years of the project to reach sexual partners of PWID.
- (1) Intensify interventions to prevent sexual transmission of HIV among PWID. (2) Identify and implement feasible interventions that can be undertaken in the last two years of the project to reach sexual partners of PWID.
- A code of conduct for outreach workers should be developed and included in all outreach training.

### 4. How effective have project activities been in influencing vulnerable population knowledge, attitudes and behaviors that prevent HIV transmission? (Goal 1)

The evaluation team does not recommend monitoring changes in vulnerable population attitudes, since changes in attitudes should be reflected in changes in behavior which are being monitored.

### 5. To what extent have project activities addressed both perceived and stated needs of beneficiaries? (Goal 1, 2, 4)

#### **PWID**

- Referrals to drug treatment services need to be more strongly linked to the outreach model and the barriers to treatment (cost and lack of anonymity) addressed
- Stigma and discrimination training be extended to rank and file police officers.
- Explore ways to provide access to other health care services that are currently not available (such as abscess, vein care and dentistry).
- Improve service provision for Female PWID, including reproductive health and family planning services.

### Sex workers

- More effectively address police harassment and gender based violence.
- Revisiting drop in center and outreach worker hours to better fit in with the lifestyle of sex workers.
- Consider re-instating mobile VCT services.
- Ensure that reproductive health and family planning information and referrals are provided via the Adara model.

### MSM

- The LaSky model be revised to reflect current best practice on condom use to ensure the model is sex positive.
- The LaSky model is revised to address the needs of MSM PLHIV.

### PLHIV

- Adopt the Kyrgyz model of incorporating stigma and discrimination training for health care providers into the continuing education program for HCP in Kazakhstan and Tajikistan.
- Develop HIV and TB adherence approaches for PWID PLHIV.

## **6. How effectively has the project addressed the integration of HIV/TB/drug treatment? (Goal 3,4)**

- Consider re-planning activities to achieve improved adherence to and decreased default from TB treatment among vulnerable populations. As for community support, it does not lead directly to improved adherence without HIV/TB/MAT integration, so put more efforts into integration.
- Develop a model “demonstration HIV/TB/MAT integrated care site” within the Dialogue Project, where clients would be able to receive all HIV, TB and medication-assisted drug treatment on a one-stop shop basis. Implementing this evidence-based approach will help to highlight all the benefits of a comprehensive integration of services to stakeholders in the Central Asian region and will serve as a foundation for subsequent scale-up of a truly integrated model of care of people with HIV and TB co-infection, who might also have other co-morbidities such as drug dependence. Due to the limited remaining time of the Dialogue Project, it is recommended to implement the model at one demonstration site, where MAT should be also currently available. It would be best to implement this recommendation in partnership with the Quality Health Care Project and USAID Central Asia TB project.
- Intensify advocacy efforts to integrate TB control activities into HIV prevention programs for all vulnerable populations, including sex workers and MSM.
- Advocate for cooperation between national TB and HIV programs, including elaboration of integration strategies, and seek state approval of these documents.
- Draw more attention at ROC and CCMs’ meetings to the issue of cooperation between national HIV and TB programs.
- Explore and address reasons why the high quality counseling component of VCT is not available in targeted TB facilities and primary health care centers. Consider analysis of success stories at selected sites and applicability of their experience to scale up.
- Advocate further integration of TB and HIV diagnostics and treatment, setting as a strategic goal universal access and provision of services on a one-stop shop basis.
- In cooperation with all relevant stakeholders, advocate for introduction MAT to those AIDS Centers, TB facilities, and primary health care centers, where it is not yet available.

- In cooperation with all relevant stakeholders, advocate for introduction TB and HIV services into already existing MAT programs to provide services on a one-stop shop basis.
- Advocate for MAT scale up simultaneously with integration of TB and HIV services.
- Advocate for further institutionalization of the voucher referral system and MIS adoption by government, contributing to availability of strategic information on TB/HIV among vulnerable populations for national decision makers.
- Assess information value of TB indicators included into national HIV surveillances, and if deemed valuable, advocate for their continuation.

**7. How effectively has the project used data to monitor its performance and guide implementation? (Cross-cutting issue)**

- TRaC survey recommendations continue to be incorporated into sessions content and information and education materials and closely monitored by the Consortium members.
- Conduct exercises to compare the integration of research findings into practice on a regular basis and implement this analysis for all vulnerable population groups

**8. Has the Dialogue Project cross-regional consortium structure and division of technical responsibilities contributed to the achievement of results? (Cross-cutting issue)**

No key issues to address

**9. How well has the project coordinated with other donors and projects working with vulnerable populations, and has existing coordination resulted in accelerated progress towards project goals and mission strategic objectives? (Cross-cutting issue)**

Simplified reporting systems are developed that can then apply across donors.

**10. To what extent are project models and results sustainable? (Cross-cutting issue)**

- Consider providing support and training to build NGO capacities for raising funds and implementing income-generating activities as an additional way to ensure greater sustainability of the Dialogue Project results, especially in Tajikistan and Kyrgyzstan.
- In Kazakhstan, it is essential to build NGO capacity to develop strong project proposals and to successfully compete for state funding. Part of this is to be able to demonstrate to the government all the good results that these NGOs are achieving through the Dialogue Project.
- In Kazakhstan, sensitize national and local governments to the importance of having vulnerable populations-targeted funding and projects as one of the key sustainability and advocacy priorities. This can be achieved by including the Dialogue-supported NGOs in the coordination structure of the project as well as into budget planning mechanisms that are responsible for budget planning for social services provision.
- In Tajikistan, consider including vulnerable populations in the list of groups of populations eligible for free testing and treatment at state health care facilities.
- In Tajikistan, consider working together with other partners to advocate for a significant mitigation/elimination of the requirement for NGOs to obtain a pharmaceutical activities license for distribution of needles and syringes, naloxone, and other harm reduction and HIV prevention materials.

- Consider the possibility of introducing a cross-country referral and voucher system as one of the potential strategies to make services accessible to mobile groups of vulnerable populations.
- In Kazakhstan, identify different options and advocate for free HIV and TB care for PLHIV regardless of their local residency status.
- Provide more training to end users of the MIS and make sure that all the remaining problems with the software are fully resolved as quickly as possible.
- In Kazakhstan, advocate for changes to social worker qualification requirements at health care facilities, in order to make sure that peer social workers are eligible to apply for these positions, since this is one of the top sustainability and advocacy priorities identified by the MDTs.
- In those countries and AIDS Centers where the position of social worker is not included in the staffing structure, advocate for the inclusion of this position in the formal staffing structure.
- Work together with the Ministries of Health to train more MDT medical specialists to strengthen the sustainability of MDTs in project countries.

## Priority recommendations to achieve program goals

**Table 13. Priority recommendations for the Dialogue Project**

<b>Recommendation</b>	<b>Goal being Addressed</b>
<p>In conjunction with the investigation of the MIS data with regard to TB adherence support and treatment completion, conduct a root cause analysis for the possible reasons for lack of improved TB treatment adherence and default and address the root causes through targeted interventions, such as advocacy for policy changes, refresher trainings, and other activities.</p> <p>Advocate for (1) the availability of MAT in TB hospitals and (2) the delivery of TB treatment in the setting that is the most accessible, non-stigmatizing and convenient for the individual PWID, and most likely to promote adherence, as recommended by WHO, UNODC and UNAIDS.</p> <p>Strengthen the national network of NGOs working with former prisoners or others vulnerable populations (such as PWID), and the referral mechanisms among the NGOs to increase adherence to and completion of TB treatment upon release from prison, particularly in Kazakhstan. The referral network in Kyrgyzstan can be used as a model.</p>	<p><b>Improved adherence to and decreased default rate from TB treatment among vulnerable populations</b></p>
<p>Undertake further study to understand why HIV knowledge among MSM in Kazakhstan and Tajikistan decreased during the first three years of the project.</p> <p>Evaluate the effectiveness of health care provider and law enforcement officer training on attitudes and behavior change.</p> <p>Undertake further study to understand why MSM who had the highest exposure to project interventions in Kazakhstan had the lowest percentage of VCT service utilization</p>	<p><b>Reduction in risk behaviors associated with HIV transmission</b></p>

### Priority recommendations for years 4 and 5 of project

#### 1. Further develop and define the Dialogue Project model

- Develop and refine the logic model by systematically reviewing all inputs and activities in light of their contribution to desired project outputs and outcomes, determine whether the quantity and quality of input and activities are sufficient to produce project outputs and outcomes, and re-program PY4 and PY5 activities accordingly
- Undertake discussion to articulate the nature of the Dialogue Project – is it a demonstration program or one that will go to scale? Either conclusion will have impact on planning for the project’s final two years.

## **2. Improve coordination/cooperation**

Harmonize outreach models implemented by different development agencies/projects via the regional round table mechanism to ensure smooth handover of a project from one development agency to another.

## **3. Address sustainability issues**

- Assess each NGO's needs in training and other technical assistance; develop a road map of capacity building with specific activities to be undertaken in the remaining two years of project implementation.
- Develop sustainability road maps for each project model and implementing NGOs.
- Apply the "meaningful involvement of vulnerable populations principles" to project models and determine how to more effectively create community ownership over the project

# Annexes

## Annex I: Kazakhstan Key Findings

Dialogue activities in Kazakhstan are implemented under the leadership of PSI, together with Project Hope, AFEW and the Kazak Union of People Living with HIV/AIDS. The project has reached a significant number of vulnerable populations through its outreach activities, and is well positioned to surpass its targets by PY4. Condom use and HIV testing have improved among prisoners and TB testing has improved among PLHIV. Changes in MSM behavior have been harder to achieve. A major challenge for the remainder of the project appears to be strengthening support for TB treatment adherence and completion.

In Kazakhstan, the Dialogue Project has reached over 22,000 PWID, SWs, MSM, prisoners, and migrants in the first three years of the project, successfully reaching 88% of the project target of 25,237 individuals from these vulnerable populations.

**Table 14. Number of individuals reached by type of vulnerable population**

Kazakhstan	Year 1	Year 2	Year 3	Total	LOP Target	% of LOP Target Reached
<b>PWID</b>	1,043	3,030	2,394	<b>6,467</b>	<b>7,167</b>	<b>90%</b>
<b>SW</b>	119	1,146	552	<b>1,817</b>	<b>2,217</b>	<b>82%</b>
<b>Migrants</b>	0	0	200	<b>200</b>	<b>500</b>	<b>40%</b>
<b>MSM</b>	368	1,005	530	<b>1,903</b>	<b>2,403</b>	<b>79%</b>
<b>Prisoners</b>	1,001	4,892	3,047	<b>8,940</b>	<b>9,840</b>	<b>91%</b>
<b>PLHIV</b>	374	1,590	796	<b>2,760</b>	<b>3,110</b>	<b>89%</b>
<i>Total persons reached</i>	<b>2,905*</b>	<b>11,663</b>	<b>7,519</b>	<b>22,087</b>	<b>25,237</b>	<b>88%</b>

\* The Year 1 Annual Report states that 2,144 persons were reached. The figure reported above was provided to the evaluation team by Dialogue on Nov. 2, 2012.

### To what extent (quantity and quality) have specific interventions been effective in contributing to the achievement of planned results?

#### *a. Reduction of risk behaviors*

Risk behavior, in terms of **condom use**, has been gradually reduced in Kazakhstan among PLHIV who have participated in the project. Use of condoms by PLHIV at last sexual intercourse has increased from 60% in 2010 to 88% in 2012.<sup>28</sup> Condom use among MSM at last anal intercourse with a male partner increased from 52% in PY1 to 60% in PY3, although the increase is not statistically significant.<sup>29</sup> Condom use data for the other vulnerable populations will be available at project end.

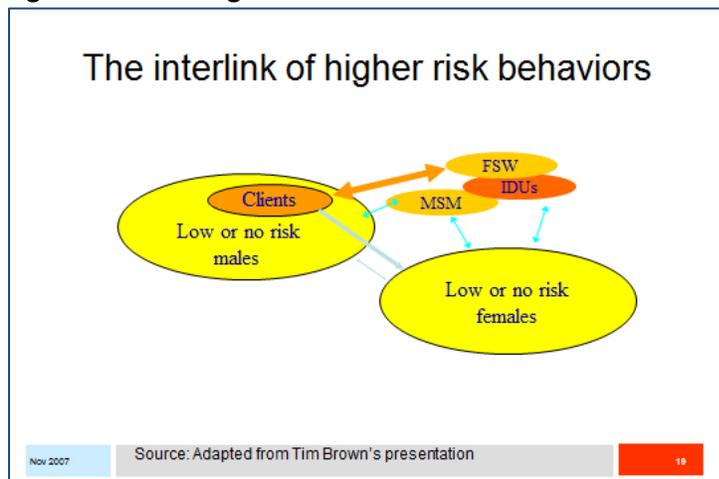
At the NGOs visited by the evaluation team, the LaSky model for MSM and the UNISON model for PLHIV are being implemented. Both models include IPC about correct and consistent condom use, distribution of IEC materials that describe correct condom use and condom distribution. IPC, distribution of IEC material and distribution of condoms are also key elements of the Break the Cycle model for PWID. Nevertheless, interviews with PWID and outreach workers indicate that insufficient emphasis has been placed on preventing sexual transmission of HIV among PWID. Primary emphasis has been placed on

<sup>28</sup> Source: MIS

<sup>29</sup> Source: MSM PY3 TRaC

harm reduction, and prevention of sexual transmission of HIV has been of secondary concern. Since the sexual partners of PWID are “bridge” populations that transmit HIV to the general population, as shown in the figure below, stronger risk behavior prevention efforts need to be placed on sexual transmission of HIV by PWIDs and their sexual partners.

**Figure 3. Link of high risk behaviors\***



\*PWID are identified as IDUs in this figure.

**Sharing of injecting equipment.** Changes in risk behavior among PWID clients, in terms of sharing injecting equipment, cannot yet be measured in Kazakhstan since the PWID TRaC is scheduled for PY5. Findings from interviews with PWID clients and outreach workers indicate that the Break the Cycle model components of IPC, distribution of IEC materials and motivational interviewing are being implemented. Needles and syringes are also available. PWID are particularly attracted to harm reduction interventions when they include distribution of naloxone for overdose prevention.

*b. Increased utilization of evidence-based HIV prevention and TB treatment services by vulnerable populations*

**HIV testing.** HIV testing has increased remarkably among prisoners served by the project in Kazakhstan, from 25% in PY1 to 76% in PY3.<sup>30</sup> In contrast, HIV testing decreased during the same period among MSM clients in Kazakhstan: from 38% to 32%.<sup>31</sup> For the remaining vulnerable population groups, data concerning changes in HIV testing will be available in PY5.<sup>32</sup>

All three outreach models, Adara, Break the Cycle, and LaSky, incorporate referrals for HIV testing. In the case of sex workers and PWID, the Adara and Break the Cycle models appear to be effective. Interviews with clients suggest that both the use of referral vouchers, which allow the client to be tested free-of-charge and without revealing his/her identity, and the use of social escorts when needed reassure the clients that they will be tested with minimal questioning and at no cost.

<sup>30</sup> Source: MIS

<sup>31</sup> Source: MSM PY3 TRaC

<sup>32</sup> TRaCs for PWID and sex workers were conducted in PY3 to provide a mid-project “snapshot” of these vulnerable populations. However, a different sampling methodology was used and thus the data cannot be compared to the TRaC data collected for the same groups during PY1.

The reason for the decrease in HIV testing among MSM project clients in Kazakhstan is unknown. Interviews with outreach workers indicate that some MSM continue to distrust HIV testing facilities for fear they will be the target of discrimination. The MSM NGO Adali in Almaty has developed an effective referral system for MSM to the Almaty AIDS center, where a MSM-friendly physician cares for MSM. In addition, the NGO has begun testing for HIV at its headquarters office, using HIV rapid tests provided by the Almaty AIDS Center, in an attempt to increase the uptake of HIV testing among MSM. (Testing is being conducted by Adali staff members who have a medical background.) If the Dialogue Project continues to support outreach to MSM in Kazakhstan, it should consider incorporation of rapid tests into the interventions of NGOs providing outreach to MSM. Doing so should facilitate HIV testing uptake by MSM who are reluctant to visit health service delivery sites. Further training of health service providers regarding stigma and discrimination toward MSM should also be considered.

**Drug treatment.** In PY2 and PY3, 374 PWID clients were referred for drug treatment in Kazakhstan. Drug treatment services in Kazakhstan are not effective in helping the clients to overcome their drug addiction, as drug treatment is not free of charge and not anonymous. A hepatitis C test is also required which most PWIDs cannot afford. Consequently, only 53% of PWID referred to drug treatment services of any kind actually sought and received these services during PY3. Further project advocacy work is needed to increase access to affordable drug treatment services for project beneficiaries.

*c. Improved TB case detection*

**TB testing.** TB testing has increased during the first three years of the project among PLHIV served by the project in Kazakhstan. Comparative data for PWID will only be available in PY5. (Active outreach for TB testing among MSM and sex workers was discontinued mid-project.)

The proportion of PLHIV served by the project that has been tested for TB in the last 12 months has increased from 80% in PY1 to 89% in PY3 in Kazakhstan.<sup>33</sup> The UNISON model includes referrals for TB testing, using the voucher system. As with HIV testing, the referral vouchers, which allow TB testing to be provided free of charge, contributed greatly to the increase in coverage in TB testing among PLHIV, according to project outreach workers interviewed. Also, the use of case management and social escorts, together with the placement of TB specialists in AIDS Centers (in the Almaty AIDS Center, for example), were also reported to have contributed to wider coverage of TB testing.

*d. Improved adherence to and decreased default from TB treatment among vulnerable populations*

More than 200 PLHIV and PWID in Kazakhstan have been assisted by community treatment supporters throughout their TB treatment.<sup>34</sup> Yet, it is unclear whether the project is achieving improved TB treatment adherence and reduced default from TB treatment among these project beneficiaries in Kazakhstan. According to the MIS, the proportion of PWID enrolled in Dialogue Project adherence support programs that completed TB treatment decreased from 75% to 67% in Kazakhstan from PY1 to PY3. For PLHIV, the decrease was even greater during the same period: from 67% to 46%. The reasons for the reductions are not known, although Dialogue Project staff believes there is a problem with

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<sup>33</sup> Source: MIS

<sup>34</sup> Source: MIS

accurate reporting for adherence support by the PY3 upgraded MIS.<sup>35</sup> They are currently verifying the MIS report for adherence support, comparing with hard copy documents.

Data reporting challenges apart, interviews with outreach workers and clients indicate that TB treatment and adherence support may be the weakest link in the continuum of TB and HIV care, in spite of the training that has occurred for outreach workers and for community leaders on community mobilization for TB prevention and treatment support. Most TB treatment defaults under the project are due to death and losing contact with the project.<sup>36</sup> One of the factors that makes adherence difficult for PWID, in particular, is that most TB patients are admitted to TB hospitals for the first two months of TB treatment. PWID do not want to remain hospitalized during the two-month in-patient period since it is difficult to inject drugs while hospitalized and because there is no MAT available in TB hospitals. Dialogue Project staff responsible for the project in Kazakhstan need to analyze why TB adherence support and treatment completion is not as effective as other project interventions, and take appropriate measures to remedy this, including improvement of case management. In addition, two policy gaps need to be addressed by the project, or in cooperation with other projects (such as TB Care I), for PWID: (1) MAT needs to be available in TB hospitals. (2) Outpatient treatment of TB needs to be available for the first two months, where MAT is not available.

For some prison populations, support for TB treatment adherence and completion is complicated by the fact that prisoners often do not remain in the geographic area served by NGO outreach services once they are released from prison. For example, 85% of the prison population attended by Kredo in Karaganda disperses to other regions of the country upon their release from prison. Since there is not a strong network of NGOs working with prisoners in Kazakhstan, a national NGO referral network for prisoners is not in place. Strengthening the national network of NGOs working with former prisoners or other vulnerable populations, and referral mechanisms among the NGOs would increase the possibility of TB patients adhering to and completing treatment upon release from prison.

*e. Continuum of care improve*

**Case management.** In Kazakhstan, case management has been introduced in city AIDS centers to improve the continuum of care for PLHIV. Depending on the city, either PSI or a contracted NGO cooperates with the city AIDS center to implement a case management approach utilizing a MDT. The MDT generally consists of a group of social workers (who are client peers) who work together with the city AIDS center staff, consisting of doctors (including a HIV physician specialist and a TB physician specialist) and nurses.<sup>37</sup> A data management person is also part of the team. Working together, the MDT provides needed medical and social services to PLHIV, including referral to the TB dispensary for TB testing and HIV and TB treatment adherence support. The contracted NGO, or PSI (depending on the center), contracts the social workers directly and also provides incentive payments to city AIDS Center staff to work as part of the MDT.

The case management approach using a MDT, has reportedly been effective in improving the continuum of care. Social workers report that the time to complete TB testing and initiate treatment has been reduced (from 4 to 5 months to 1.5 months at the Almaty AIDS Center), TB case detection has increased,

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<sup>35</sup> During PY3, the MIS was modified to provide more user-friendly reports and detailed information on adherence support.

<sup>36</sup> Source: USAID Dialogue on HIV and TB Project Annual Performance Report: Year Three

<sup>37</sup> Social workers are facility-based and outreach workers are community-based.

TB and ARV treatment adherence has improved, AIDS-related deaths have decreased and support groups have been created enabling HIV+ persons to accept and disclose their status. MDTs have also collaborated with the Bureau on Human Rights to help clients to resolve their legal problems (i.e., lack of proper identification).

The sustainability of the case management/MDT approach in public health facilities is a major challenge. Kazakhstan requires that social workers working in the AIDS Centers have university degrees. The project social workers don't meet the educational requirements to be a social workers and thus can't be hired by the city AIDS Centers.

In both the Almaty AIDS Center and the Temirtau AIDS Center, where project support for MDT was recently discontinued, service provision to vulnerable populations has been affected. The Almaty AIDS Center, for example, reports that since the MDT was discontinued it no longer has a TB specialist; this position used to refer TB patients to the social workers for testing and treatment adherence support. Since funding for the TB specialist was discontinued, social workers try to meet PLHIV in the center's corridors, hoping they will disclose their status and discuss their TB testing/treatment needs. The lack of the TB specialist has become the missing link in providing the continuum of care in this center.

**Referral vouchers.** As mentioned earlier, the voucher system enabling referrals of vulnerable populations to services such as HIV and TB testing, has been an effective mechanism to strengthen the continuum of care. However, it has limitations (i.e., it can't be used by foreigners) and its sustainability is questionable. With the introduction of the so-called "Edinaia Sistema Zdravookhraneniya" or Unified Public Health System in Kazakhstan, citizens are entitled to receive free health care at the polyclinics, primary health care centers, or at their places of registered residence. Foreigners and/or internal migrants without a registered residence at a given area cannot receive free health care under this system. The percentage of such clients (foreigners and internal migrants) in the total number of clients served by the Almaty AIDS Center MDT is fairly significant, ranging between 30 to 40%, making the issue of vouchers a top advocacy priority for the sustainability of the voucher system.

*f. Data better used for decision making*

Since 2010, 89 persons have been trained and 30 organizations have received technical assistance in strategic information. The project appears to be using data effectively for decision making. A good example of how data has been used occurred in PY3 when the project detected that the number of referrals slightly decreased. Meetings were held with sub-awarded NGO program staff to find out the causes of referral decline which revealed that fewer clients were referred because they were previously tested for HIV and TB in the previous 12 months. Some were tested in prison, others were tested when being treated for drug addiction, and others participated in HIV sentinel surveillance and were tested. Thus, to track the trend in referrals to HIV and TB testing services project staff detected a need to update the MIS to track if clients have received testing services in the previous 12 months and were therefore not referred by outreach workers.

**To what extent have project activities addressed both perceived and stated needs of beneficiaries?**

The project appears to be meeting some of the perceived and stated needs of the beneficiaries in Kazakhstan. Several gaps exist.

With regard to PWIDs, the project appears to be meeting their needs in terms of harm reduction to prevent HIV transmission, but not prevention of sexual transmission of HIV. Overdose treatment

through distribution of Naloxone (which just began in Kazakhstan and is funded by PSI) is valued by the clients and is seen as a positive motivating factor to participate in project activities. Referrals to drug treatment services need to be more strongly linked to the outreach model and the barriers to treatment (cost and lack of anonymity) need to be addressed. In addition, a gender-specific approach to the specific needs of female PWID needs to be addressed. A stronger examination of whether the Break the Cycle model meets the needs of younger (under age 30) PWID should also be undertaken. As mentioned earlier, in-patient treatment of TB for the first two months of treatment is a significant barrier for PWID, since MAT is not available.

With regard to sex workers, the evaluation team did not have the opportunity to visit NGOs or this group of beneficiaries in Kazakhstan. Nevertheless, it is difficult for the project to effectively reach this group due to police repression of sex work on the street and the need for sex workers to work in closed places, such as saunas. Significant work is required on the part of project staff to gain access to sex workers in such locations. Referral of sex workers for health services is difficult because health facilities are open during the day when sex workers sleep. Provider stigma and discrimination continue to be barriers for sex workers to receive services in primary health care centers. The project has attempted mobile VCT services, which increased the proportion of sex workers tested for HIV. When mobile VCT services were discontinued by the Almaty AIDS Center due to funding constraints, testing decreased. This suggests that mobile VCT is a more effective way to reach sex workers than exclusively through referrals. In addition, sex workers have unmet needs with regard to family planning and reproductive health services.

With regard to MSM, the project is meeting the needs of this highly stigmatized and discriminated vulnerable population through implementation of the LaSky Model, which is considered to be effective by those interviewed, particularly for young MSM. The voucher system for referrals is appreciated by clients, since it allows them to receive services anonymously and without documentation. However, MSM do not have strong health-seeking behavior and motivating MSM to use services is a continuing project challenge. With regard to the LaSky model, not all of its original components (compared to the original Russian model) have been implemented by the project due to cost limitations. According to those NGO staff interviewed, it does not employ enough promotional and motivational materials. Also, the LaSky branding is mixed with the project branding (traffic light sign), which is considered by the beneficiaries to be irrelevant to gay culture.

With regard to prisoners, the project is meeting the needs of inmates and former prisoners through implementation of the START Plus model. The model appears to be most effective while the clients are in prison, as only a small proportion of the inmates go on to participate in the release component of the program after leaving prison. While in prison, needles/syringes are available for PWID, but the availability of condoms is limited. According to those interviewed, prisoners very much value project activities while they are in prison. However, beneficiaries of this model have very basic needs upon release from prison, ranging from documentation, housing, employment, and clothing, to soap and a shower. Often project social workers/outreach workers are the only ones released prisoners can rely on for support. As the Dialogue Project cannot provide all of the support prisoners need upon release from prison, more effort is needed to connect NGOs working with former prisoners and other vulnerable populations (particularly PWID) in a network so that a strong referral system for additional services is in place. In addition, overdose prevention through distribution of naloxone should be included in the model.

With regard to PLHIV, implementation of the UNISON model has been successful and has made a significant structural change as to how the TB and HIV testing and treatment needs of PLHIV are met in

Kazakhstan. However, the model needs stronger integration of MAT, a topic that is still sensitive in Kazakhstan. As many PLHIV are also PWID, they are in need of MAT. Yet, narcologists work for MDTs only at sites where MAT is available and Kazakhstan has taken only the first steps to provide MAT.

For all vulnerable populations in Kazakhstan, and particularly PWID and PLHIV, more outreach work needs to be done with sexual partners to prevent sexual transmission of HIV and educate about TB.

Stigma and discrimination continue on the part of health care providers, particularly at TB dispensaries and primary health care facilities. The project should intensify work to reduce stigma and discrimination at these locations in order to better meet the HIV and TB needs of vulnerable populations.

One area in which the project needs to focus is gender. Interviews with NGO leaders and their staff indicate that the Dialogue Project has not provided orientation with regard to the gender-specific needs of the different vulnerable populations.

### **How effectively has the project addressed the integration of HIV/TB/drug treatment?**

In Kazakhstan, ARV is available at all TB facilities for TB in-patients. However, testing is done in specialized facilities – HIV testing is done in AIDS centers; TB testing is done in TB facilities. The reason for this is that a person diagnosed with TB must be treated at the place of diagnosis. The project has addressed this integration gap through case management, whereby social workers/outreach workers accompany clients to TB dispensaries for TB testing. TB treatment is provided as an in-patient service for the first two months of treatment in TB hospitals where ARV treatment is available. The Ministry of Health and other stakeholders are currently working on a decree on TB and HIV services collaboration.

## **Annex II: Kyrgyzstan Key Findings**

Dialogue Project activities in Kyrgyzstan are implemented in the four project sites of Chui Oblast, Osh Oblast, Jalalabad Oblast and Bishkek city under the leadership of PSI Central Asia, together with Project Hope, and AFEW. The Dialogue Project has reached over 24,638 vulnerable populations in its first three years, which is 83% of the project target of 29,692 individual vulnerable populations.

According to the project MIS, condom use, TB testing, knowledge of HIV transmission, and the knowledge that TB is curable have improved among PLHIV. HIV testing and the knowledge that TB is curable have also improved among prisoners. According to TRaC surveys, condom use, HIV testing, and knowledge of HIV transmission have improved among MSM.

Project beneficiaries expressed their appreciation of the comprehensive services they can receive anonymously and free of charge through the voucher referral system. PWID expressed particular appreciation for OD prevention services, including Naloxone distribution, and drop-in centers. PWID who are former prisoners testified to the positive changes that the START Plus model had provided to their lives, including referrals to NGOs working with PWID. The UNISON model was highly appreciated by PLHIV, since it enabled them to receive comprehensive diagnostics, treatment, and social support services. MSM stated that the establishment of the Kyrgyz MSM community is an achievement of the Dialogue Project in-country.

The Kyrgyzstan country project piloted promising models that might be scaled up within the region. Among them were the introduction of MDT (UNISON model) at primary health care centers; institutionalization of continuous education for health care providers; tailoring services for different subgroups of MSM; and a referral system inside the NGOs' network for tracking former prisoners, so they would not be lost after their release.

However, there are also some challenges. One major challenge for the remainder of the project is strengthening support for TB treatment adherence and completion. Both MIS PMP indicators and feedback received from implementers during the evaluation demonstrated that these project targets are hard to achieve only by community support. There is a need for deeper integration of HIV/TB/MAT services. Another issue is scale up and sustainability of the introduced models. Police harassment as well as stigma and discrimination within health centers remain obstacles for project activities.

### **How effective have project activities been in reaching various vulnerable populations?**

Through group discussions with implementers, project activities were determined to be effective in reaching vulnerable populations. Outreach in the places where vulnerable populations congregate is the main way of reaching clients for all groups. In addition, the project also used the Internet and social networks as primary means of reaching MSM. PLHIV were also reached by referrals from medical doctors. However, it is difficult to accurately evaluate the project's coverage in terms of the country HIV/TB response, since there is no new reliable data on vulnerable population size estimation in Kyrgyzstan. According to the PSI team in Kyrgyzstan, figures for vulnerable population sizes are out-of-date and underestimated.

**Table 15: Number of vulnerable populations reached by population type**

Kyrgyzstan	Year 1	Year 2	Year 3	Total	LOP Target	% of LOP Target Reached
<b>PWID</b>	1,216	6,751	3,314	<b>11,281</b>	<b>13,681</b>	<b>83%</b>
<b>SW</b>	571	2,163	1,797	<b>4,531</b>	<b>5,581</b>	<b>81%</b>
<b>Migrants</b>	0	0	446	<b>446</b>	<b>800</b>	<b>56%</b>
<b>MSM</b>	622	582	376	<b>1,580</b>	<b>1,880</b>	<b>84%</b>
<b>Prisoners</b>	1,038	2,723	2,374	<b>6,135</b>	<b>6,735</b>	<b>91%</b>
<b>PLWH</b>	115	300	250	<b>665</b>	<b>1,015</b>	<b>66%</b>
<b>Total</b>	<b>3,562</b>	<b>12,519</b>	<b>8,557</b>	<b>24,638</b>	<b>29,692</b>	<b>83%</b>

**Country context.** In Kyrgyzstan, NGOs and civil society play a leading role in addressing the HIV and TB epidemics among vulnerable populations. International funding is very important, given that the state budget supports only health care providers' salaries and the maintenance of health care facilities. All other activities are funded by international donors, including ARV and TB treatment supplies. Kyrgyzstan receives financial support from the Global Fund for both HIV and TB. Kyrgyz state authorities, especially the MOH, are open to cooperation with civil society and are ready to support necessary changes in the health care system. At the same time, implementation of state decisions is very weak; therefore, NGOs sometimes take over the role of state decisions implementers. For example, NGOs informed primary health care centers about the MOH order that obliged the centers to introduce MDTs to work with PLHIV and NGOs followed up the progress of implementation. Political instability in Kyrgyzstan causes frequent replacements of key personnel within the health care system; this complicates project implementation.

**To what extent (quantity and quality) have specific interventions been effective in contributing to the achievement of planned results?**

The models and their corresponding TOPS are acknowledged to be especially appropriate for vulnerable populations needs and very effective in achievement of planned results in increase of vulnerable populations coverage with outreach services to prevent the spread of HIV and TB, behavioral risk reduction, increase in use of HIV and TB services, and TB case detection improvement. However, planned results in HIV and TB treatment adherence improvement were not achieved.

Implementers and beneficiaries positively evaluated a social marketing approach to information distribution. Key messages are relevant to the vulnerable populations' needs and culture, clear and easy to grasp, and effective for motivating behavioral change. The project's comprehensive approach to services, including motivational counseling, referrals, and escorts to services (TOPS) was unique in the country. Its inclusiveness contributed to effective reach of vulnerable populations.

*a. Reduction of risk behaviors*

Risk behavior, in terms of condom use, has been reduced among PLHIV and MSM. MIS data shows that use of condoms by PLHIV at last sexual intercourse has increased from 36% in 2009 to 71% in 2012 within the project. The TRaC survey shows that condom use among MSM at last anal intercourse with a male partner increased from 42% in PY1 to 71% in PY3 country-wide. Condom use data for the other vulnerable populations will be available at project end.

All models include a component on sexual prevention of HIV transmission. Nevertheless, interviews with representatives of NGOs who work with PWID indicated that this part of prevention is insufficiently emphasized. Since the sexual partners of PWID are “bridge” populations that transmit HIV to the general population, stronger risk behavior prevention efforts need to be placed on sexual transmission of HIV by PWID.

**Sharing of injecting equipment.** Changes in risk behavior among PWID, in terms of sharing injecting equipment, cannot yet be measured in Kyrgyzstan since the PWID TRaC is scheduled for PY5.

*b. Increased utilization of evidence-based HIV prevention services by vulnerable populations*

**IPC.** The cumulative number of individual vulnerable populations reached with individual and/or small group interventions that are based on evidence has increased from 7,967 in PY2 to 11,281 in PY3 for PWID; from 2,734 to 4,529 for sex workers; from 1,204 to 1,580 for MSM; and from 415 to 665 for PLHIV, according to MIS PMP indicators. Targets were reached and exceeded.

**HIV testing.** According to MIS PMP indicators, HIV testing has increased remarkably among prisoners. In PY1, 16% of prisoners said they had received VCT services in the last 12 month. In PY3, that figure rose to 83%. According to TRaC survey among MSM, there was a similar increase, from 26% to 62%. For the remaining vulnerable populations, data concerning changes in HIV testing will be available in PY5.

All three outreach models used in Kyrgyzstan, Adara, Break the Cycle, and LaSky, incorporate referrals and escorts for HIV testing. All three models appear to be effective. Interviews with clients suggest that both the use of referral vouchers, which allow the client to be tested free-of-charge and without revealing his/her identity, and the use of social escorts, when needed, reassure the clients that they will be tested with minimal questioning and at no cost.

**Drug treatment.** The cumulative number of referrals to drug treatment increased considerably, from 538 in PY2 to 1,592 PY3, and targets were reached and exceeded. This increase is a result of the wide availability of MAT in Kyrgyzstan.

*c. Improved TB case detection*

**TB testing.** The cumulative number of PWID referred and tested for TB via community-level referral system increased from 539 in PY2 to 919 in PY3 for PWID, and from 363 to 671 for PLHIV. TB testing in the last 12 months increased during the first three years of the project among PLWH, from 25% in PY1 to 92% in PY3 (according to MIS PMP indicators). Targets were reached and exceeded. Interviews with NGO representatives demonstrated that the UNISON model is very effective in reaching PLHIV with TB screening and other services. Comparative data for PWID will be available only in PY5.

*d. Improved adherence to and decreased default from TB treatment among vulnerable populations*

Improved TB treatment adherence and reduced default from TB treatment is one project result that is not being achieved. In PY3, 74% of PLHIV clients and 65% of PWID clients were enrolled in TB adherence support program. The target rate of 84% was not reached.

According to footnotes in the PMP, this indicator as measured by the MIS, was not reported accurately and now is being verified with hard copy documents. But interviews with implementers and beneficiaries also showed that adherence to TB treatment remains problematic for PWID. A possible

explanation of the situation is that community support is not the best activity to help improve adherence, with HIV/TB/MAT integration being a more effective means.

*e. Continuum of care improved*

Continuum of care was improved by introduction of Voucher referral system (VS); client case management, escorts, community support, and multidisciplinary team (MDT) approach to work with PLHIV.

**Voucher system.** The voucher system is an example of positive structural change to the Kyrgyz health care system, achieved by Dialogue. If the voucher system is institutionalized, it can provide a sustainable basis for every model to provide vulnerable populations with accessible HIV and TB services within Kyrgyzstan's health care system. Some of the advantages include:

- The voucher system guarantees accessibility of HIV and TB services to vulnerable populations without ID and residence registration
- Services provided free of charge on a voucher basis
- The voucher system helps health care facilities in reporting HIV and TB indicators set by the National HIV and TB Programs
- Health care practitioners are interested in achieving target indicators since this influences their wages; therefore, they are interested in providing services to vulnerable populations. This, in turn, reduces discrimination against vulnerable populations in health care facilities.

According to interviews with beneficiaries and implementers, **case management and escorts** to services were acknowledged to be effective in improving access of vulnerable populations to services, reducing also stigma in the health care system.

The introduction of the MDT approach (UNISON model) in working with PLHIV is another Dialogue Project success in Kyrgyzstan. Initially, MDT addressed the problem of the vertical and centralized post-Soviet health care system, under which a doctor was allowed only to treat those diseases covered by his/her narrow area of specialization. For example, HIV specialists could only treat HIV and only do so in AIDS Centers. TB specialists were only able to treat TB and only in TB dispensaries. This complicated diagnostics and treatment for people who had multiple diagnoses. The MDT approach was piloted in Kyrgyzstan in a Family Health Center (Isykata) that is a primary health care facility. There, an infectionist or STI doctor was involved simultaneously along with a social worker in MDT and both received wages from the NGO 'Antistigma'. This NGO also has outreach workers who focus on training and education, adherence support, case management and community support. The NGO also supports self-help groups, motivational packages, and food supplies. The MDT Model demonstrated numerous advantages:

- PLHIV receive access to free and comprehensive medical services
- PLHIV receive community support and adherence support
- PLHIV with TB or STI co-infections were diagnosed and treated
- Coverage of PLHIV with comprehensive services was raised

f. *Data better used for decision making*

In 2010 and 2011, 45 NGOs were provided with technical assistance for strategic information, including the training of 94 persons. The project has effectively used MIS data to monitor its performance and guide implementation. NGOs enter data into the MIS from their paper back-up documents, which are then aggregated in the PSI office. PSI follows up on the progress of every NGO, and uses these data for annual planning, including PMP annual indicators.

Data from TRaC and MIS are also used for (PSI) DELTA activities, which are internal programmers' meetings for the development of key communication channels and messages for vulnerable populations.

TRAC data were also discussed in DDM (Dashboard Decision Making) Workshops with implementers and stakeholders, where programmatic decisions are elaborated on a basis of survey results.

**To what extent have project activities addressed both perceived and stated needs of beneficiaries (PWID, sex workers, MSM, prisoners, PLHIV and other vulnerable populations)?**

Another notable success of the Dialogue Project in Kyrgyzstan is that it takes a comprehensive approach to meeting the needs of various vulnerable populations. In the project implementers' opinion, this is another unique characteristic of the project that differentiates it from Global Fund programs. Vulnerable populations are more eager to listen about HIV / TB prevention and treatment when their other urgent needs are met.

The project met the need of vulnerable populations by providing services anonymously, free of charge, and making medical help available without personal identification or registration. For PWID, OD prevention with naloxone, basic needs (housing, hygiene) covered by the drop-in center in Osh, and drug treatment referrals were the most valued. PWID, PLHIV and prisoners received assistance in recovery of documents, which was very important to them. Community support was highly appreciated by all vulnerable populations. Additionally, for the MSM community in Kyrgyzstan, the Dialogue Project was a starting point in uniting and increasing their visibility. The social integration component for former prisoners was highly appreciated by clients. Former prisoners provided touching testimonies of being referred by START Plus teams to NGOs working with PWID after their release. These clients were grateful to the project for getting housing, identification, necessary treatment, and employment assistance.

Some needs of vulnerable populations remain unmet. Harassment by law enforcement remains an urgent issue among PWID, sex workers, and MSM. PWID can be detained for carrying clean syringes, despite the fact that this is a formal violation of their rights. Stigma and discrimination in health care centers remains an issue as well; however, improvement has been detected by those interviewed. PWID are also suffering from abscesses and dentistry problems and require vein surgery care and dentist services. Many sex workers and PWID still do not have personal identification (IDs), which limits their access to treatment and other services.

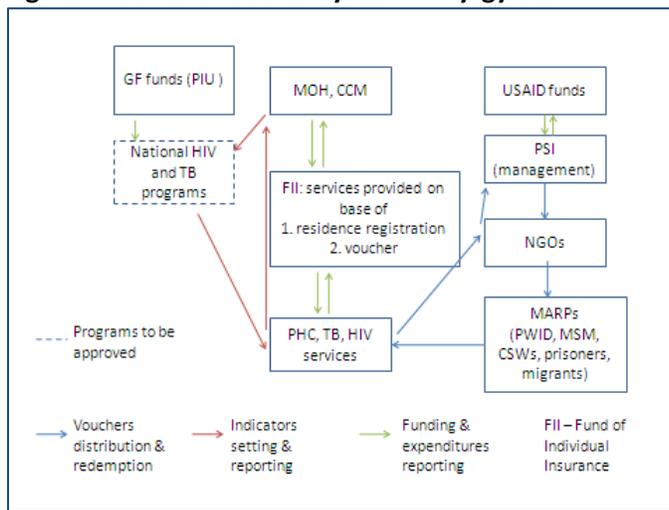
**To what extent are project models and results sustainable?**

Sustainability in Kyrgyzstan is a problematic issue because of the lack of state funding. The national budget is not capable of covering all necessary needs in health care. However, the Dialogue Project

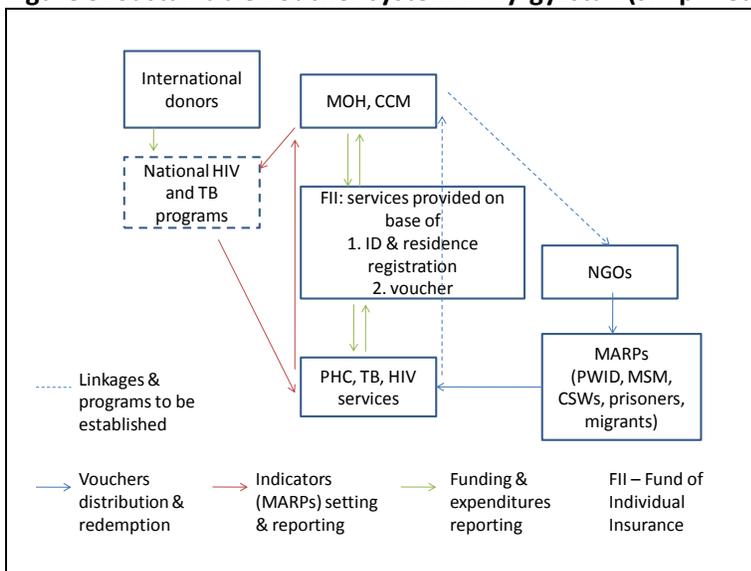
Consortium does its best for institutionalization of models and for appropriation of models by the Global Fund, which is the most important source of funding for HIV and TB in Kyrgyzstan. In order for the voucher system to be sustainable, several changes are needed:

- Initially, vouchers should be distributed by the MoH to NGOs, and then reported back to the MoH.
- Voucher service should be implemented in all health care facilities. Currently, some facilities do not accept vouchers and do not provide services to vulnerable populations.
- Vouchers need to have a code for every specific vulnerable population to ensure that MoH receives data on exact subgroups of vulnerable populations, since now there is no any indication on a voucher to what particular group a client belongs.

**Figure 4. Current voucher system in Kyrgyzstan**



**Figure 5. Sustainable voucher system in Kyrgyzstan (simplified model)**



## UNISON Model

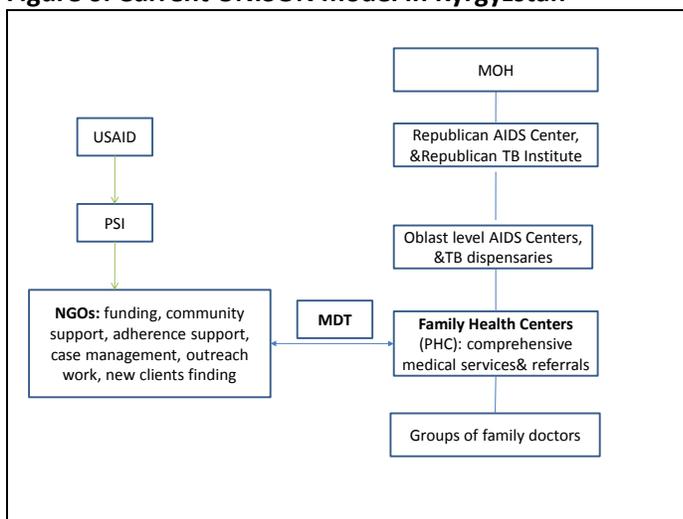
The sustainability of the UNISON model is already guaranteed by the following conditions:

- The MDT model is formally secured in clinical protocols on PLHIV treatment and care. If medical personnel follow these protocols, they work as part of a MDT.
- The MDT model is also formally secured in MoH orders that determine the work of MDTs in primary health care centers
- ARV prescription and distribution in primary health care centers is secured in a corresponding MoH order
- Health care providers are interested in providing PLHIV with services because they have to report to MoH on indicators related to PLHIV set by National HIV and TB programs. Successful reporting correlates with their wages; this, in turn, contributes to reducing discrimination.

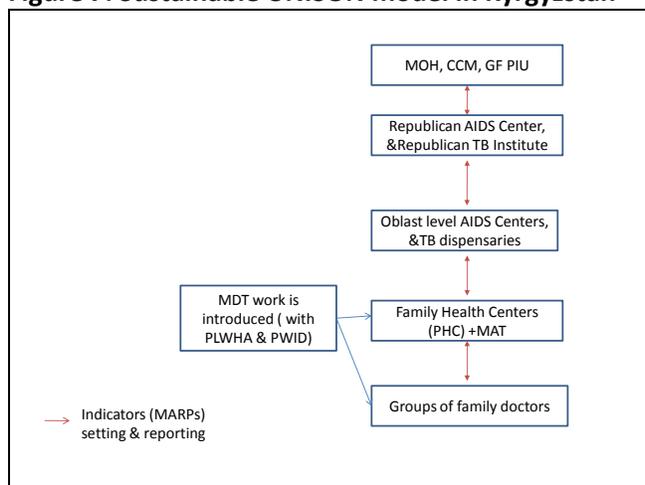
There are some additional actions that are needed to establish sustainable change all over the country:

- Actual implementation of the MDT approach throughout Kyrgyzstan in primary health care centers, including groups of family doctors in remote villages
- Capacity building for health care providers in primary health care centers, on working with vulnerable populations and overcoming stigma/discrimination
- Capacity building for health care providers in primary health care centers on HIV and TB diagnostics and treatment corresponding with clinical protocols
- Establishment of regular appointments for social workers within primary health care centers with defined job responsibilities on PLHIV case management, care and support
- Establishment of rooms for PLHIV self-help groups and counseling in primary health care centers
- Further integration of HIV/TB/MAT services.

**Figure 6. Current UNISON model in Kyrgyzstan**



**Figure 7. Sustainable UNISON model in Kyrgyzstan**



### **Adara & Break the Cycle Models**

Sustainability will be achieved if the Global Fund program includes the models in its prevention programs in Kyrgyzstan. To achieve this, the following actions are necessary:

- Collaboration between PSI and the Global Fund PIU
- Capacity building of Global Fund implementing partners to work within the frameworks of Adara and Break the Circle Models
- Distribution of Adara's and BTC's edutainment materials among NGOs supported by the Global Fund
- Provision of technical support to the NGOs that implemented the Adara and BTC models in applying for Global Fund grants
- Strengthening of the voucher system of referrals and its adoption by Global Fund-supported projects
- Work with law enforcement on overcoming stigma and discrimination

### **START Plus Model**

The biggest issue for the prison component is its sustainability after January 2013, when the Dialogue Project finishes its work on this program component. According to the opinion of model implementers, the best way to sustain the model at the current moment is to find donor funds and continue implementation through NGOs.

Currently, AFEW works with six prisons under the Dialogue Project and with one prison under the EU Bridge project. AFEW is working to incorporate the START Plus model into the standard release processes for prisoners. It is expected that prison system personnel, primarily social workers and penal inspectors, will be responsible for social support and reintegration of prisoners into society. This also carries cost implications to introduce and train new staff. Another problem to be addressed is the frequent turnover of the relevant personnel. For example, currently social workers are considered to be the lowest position in a prison and are automatically promoted after one year. In this way, training of these personnel is ineffective, since they do not remain in the position long enough to be effective.

Despite the fact that AFEW is attempting to institutionalize the entire model, sustainability of a social support and reintegration component questionable. For example, psychologists and social work

positions were introduced into prison system. However, they do not address case management and social reintegration, and are occupied with other responsibilities. What is more, prisoners do not trust the prison administration, and cellmates who cooperate with the administration at any point are punished under the informal code of conduct among prisoners. To change this situation, general prison reform is required, which is beyond the capacity of the Dialogue Project or any other health care project.

### **How effectively has the project addressed the integration of HIV/TB/drug treatment?**

Dialogue was the first project that raised the question of HIV and TB services integration for vulnerable populations in Kyrgyzstan. Before the project, the issue of TB services for vulnerable populations was not addressed. The project has managed to introduce a great positive change in this area.

The main achievements in the area of prevention is that existing networks of NGOs already doing HIV prevention work started increasing knowledge about TB among all vulnerable populations. Outreach services provided to these populations included TB counseling, referrals, and escort to TB-testing, and referral and escort to treatment in case of a positive TB test result. However, in order to achieve sustainable change, advocacy is needed to introduce the TB component into HIV programs supported by the Global Fund, as well as to introduce work with vulnerable populations into TB programs supported by the Global Fund.

Much positive change was achieved in TB diagnostics and treatment for PLHIV. Before the Dialogue Project, patients with HIV/TB co-infection had difficulties in receiving treatment, because both AIDS Centers and TB dispensaries were reluctant to take responsibility for such patients and would redirect them from one place to another. As a result of round table meetings and corresponding MoH orders, cooperation between HIV and TB services has been established, and now patients with co-infection receive treatment in accordance with relevant clinical protocols.

The MDT approach to working with PLHIV in primary health care centers, piloted by the Dialogue Project in Chui oblast, includes cooperation between the infectionist and physician. Every PLHIV goes through TB testing and is referred to TB treatment. However, some PLHIV testing positive for TB still have difficulties in getting treatment if they do not have personal documents or registration.

There is not enough integration of MAT programs and TB treatment, which is highly relevant for TB treatment adherence among PWID. Only three TB treatment facilities provide MAT. There were no drug treatment dispensaries with MAT programs that provide either TB treatment or ARV treatment. Therefore, TB treatment adherence among PWID is insufficient.

Insufficient integration of drug treatment and TB services also includes problems with collecting data. There is no data about TB cases among PWID, since TB dispensaries do not take into account drug use treatment, and drug treatment dispensaries do not count TB cases.

Finally, Kyrgyzstan also experiences problems with TB treatment supplies, namely a lack of MDR treatment supplies.

## Annex III: Tajikistan Key Findings

Dialogue Project activities in Tajikistan are implemented in the five key program sites of Dushanbe, Vakhdat District, Qurghonteppa, Kulob, and Khudjand under the leadership of PSI, together with Project Hope, AFEW and in partnership with the International Office for Migration (IOM). The project has reached a significant number of vulnerable populations through its outreach activities. In total, 22,824 people representing vulnerable populations were reached by Dialogue in the first three years of project, representing 71% of the project target of 32,114 people to be reached.

**Table 16: Number of vulnerable populations reached by population type**

Tajikistan	Year 1	Year 2	Year 3	Total	LOP Target	% of LOP Target Reached
<b>PWID</b>	1,143	4,373	2,658	8,174	<b>12,574</b>	<b>65%</b>
<b>SW</b>	1,454	3,834	1,850	7,138	<b>10,004</b>	<b>71%</b>
<b>Migrants</b>	0	0	536	536	<b>1,000</b>	<b>54%</b>
<b>MSM</b>	215	659	418	1,292	<b>1,724</b>	<b>75%</b>
<b>Prisoners</b>	606	1,759	2,333	4,698	<b>5,388</b>	<b>87%</b>
<b>PLWH</b>	159	474	353	986	<b>1,424</b>	<b>69%</b>
<b>Total</b>	<b>3,577</b>	<b>11,099</b>	<b>8,148</b>	<b>22,824</b>	<b>32,114</b>	<b>71%</b>

In Tajikistan, the evaluation team conducted field visits to Dushanbe and Kulob and held individual and group interviews with individuals from vulnerable populations as well as representatives from the following stakeholder organizations: UNDP, the Global Fund Project Implementation Unit, Republican AIDS Center, Public Association (NGO) “Marvorid,” Public Association “Vita,” Public Association “Anis,” Public Association “SPIN Plus,” and Public Association “Legal Support.” The team also had an extensive meeting with members of the Dialogue Project Consortium, including PSI, AIDS Foundation East-West, and Project HOPE. This meeting was also attended by a representative from IOM. At the end of the visit to Tajikistan, the team also had a debriefing meeting with colleagues from USAID Dushanbe, USAID Almaty, and USAID Washington, DC.

The following issues emerged in the course of the evaluation team’s work in Tajikistan related to the principal evaluation questions:

### **How effectively has the project used data to monitor its performance and guide implementation?**

Overall, both annual and quarterly performance reports contain extensive and detailed information on the implementation of the project in Tajikistan, including the key challenges faced by the partners. Similarly, proposed yearly implementation plans contain country-specific outlines of activities to be carried out during the upcoming period. TRaC studies include both key and extensive recommendations that are developed to inform and guide implementation. Finally, all implementing partners have been provided with and trained in the use of database/program MIS.

While in general the project in Tajikistan followed the original implementation plans, there are a few issues or activities that have either been left unaddressed or have not been followed to the full extent.

Among these issues and activities is insufficient advocacy activities (jointly with the Quality Health Care Program) for scale-up of opioid substitution therapy (OST) and its expansion to Khatlon region (Kulob), where narcology/drug treatment physicians reportedly charge very high informal fees for a short-term in-patient detox course at state dispensaries.

Another issue is the absence of consistent connection between the recommendations from TRaC surveys and information and education materials provided by the Dialogue Project to its beneficiaries. As observed by the team during its visit to Tajikistan, the majority of I&E materials that were currently available were developed and donated by the Global Fund (UNDP Project Implementation Unit, which functions as a Principal Recipient) and other partners, such as AFEW. These materials were not necessarily informed by data generated through TRaCs.

### **How effective have project activities been in reaching various vulnerable population groups?**

The Dialogue Project appeared to be very effective in reaching various vulnerable populations groups. The team observed, in the course of all interviews in Tajikistan, that implementing partners consistently achieved their targets in reaching various vulnerable population groups. With Dialogue-funded partners often being one of the few vulnerable populations-friendly service providers at a given site, the demand for their services was normally very high, as in the case of drop-in centers for drug users. At the same time, the team noticed that meeting the coverage targets was one of the key concerns for project coordinators and outreach workers were strongly encouraged to seek and reach new unique clients. With implementing partners commonly surpassing their coverage targets, it was understandable that Consortium partners felt that they could further scale-up coverage and raise the targets for implementing partners.

With this said, the team had a feeling, on the basis of conversations with outreach workers, that ‘chasing’ coverage targets and fulfilling the plans of reaching new clients has put a significant pressure on them. Some outreach workers suggested that a substantial amount of their time was spent on ‘finding’ and engaging with new clients. With the cumulative number of newly reached clients growing, they were unable to devote an adequate amount of time to those who have already been reached, leaving the latter without adequate case management and perhaps not having sufficient time to devote to delivering appropriate messages. Therefore, the quality of work with already reached clients was reportedly suffering as a result of pressure to fulfill the plans for reaching new clients.

### **To what extent have project activities addressed both perceived and stated needs of beneficiaries (PWID, sex workers, MSM, prisoners, PLWHA, and other vulnerable population groups)?**

During interviews with the evaluation team, Dialogue Project beneficiaries (and program implementers including outreach workers) expressed their appreciation of and satisfaction with referrals for services such as VCT, testing for sexually transmitted infections, drug free treatment and drop-in centers, and TB testing and treatment services. It was stressed that the introduction of the voucher system was particularly helpful, as was the provision of escorts. In particular, escorting clients to respective services helped to avoid waiting lines and stigmatization and discrimination by health care providers. Furthermore, as many members of vulnerable population groups had some sort of a legal problem (e.g., no passport or other ID document, no registered place of residence, or a similar issue) that often served as an obstacle to receiving state services/benefits/employment, the addition of the legal support component was very much welcomed.

In many places visited by the evaluation team (Marvorid, SPIN Plus, Anis), implementing partners were also providing low threshold services to their clients including showers, laundry service, day time meals and other services, which were all instrumental in meeting clients' various needs and retaining them in the project. Distribution of naloxone to clients was a particularly important strategy adopted by the project to prevent fatal drug overdoses. The team heard very encouraging testimonies from clients and outreach workers on the successful use of naloxone throughout project sites.

Discussions with MSM and sex workers confirmed that both condoms and lubricants were made available to these groups through the Dialogue Project. In Dushanbe, SPIN Plus was the only organization in Tajikistan that operated a center for female drug users (established through funding from CARHAP) and was able to meet their specific needs, including day time accommodation of children. Drug free treatment was also made available to and highly appreciated by clients in Kulob (NGO "Anis"). NGO Anis was also able to provide this service to a few clients from Dushanbe and Qurghonteppa, and the team has heard very positive feedback from these clients. Beneficiaries met by the team also appreciated receiving motivational packages, although it was noted that both the number and the content of the packages distributed to the clients decreased significantly over the recent past. MDT services were particularly appreciated by clients in Dushanbe, suggesting that this was one of the most successful interventions rolled out by the Dialogue Project. However, available MDTs were clearly not sufficient to serve the increasing number of clients. It was also noted that there was a great shortage of qualified and friendly physicians to work in the MDTs, and those doctors who were involved in MDT (Dushanbe) were extremely overloaded and did not have time for regular meetings and sessions with other MDT members.

The team also noticed that there was a greater demand for IEC materials developed in the Tajik language, as emphasized by all clients and outreach workers who were interviewed during the visit to Tajikistan. These materials, however, were found to be in short supply both at the offices of implementing partners and with outreach workers. Sex workers in Dushanbe lamented the lack of free STI treatment, which resulted in an unfortunate situation whereby beneficiaries would be able to receive information and diagnosis, but no treatment.

Furthermore, in discussions with beneficiaries and implementing partners at all sites and particularly in Kulob, protection from police harassment, abuse and physical violence was underlined as one of the key needs of the beneficiaries. In addition to continued provision of trainings to the police officers on harm reduction, HIV prevention and human rights of vulnerable populations, establishing an effective mechanism to deal with police violence (including the prosecution of offenders) seems to be much needed. This can be discussed and advocated for through the country level working group. While OST was in great demand in Dushanbe and there was a clear need for scale-up of OST programs, beneficiaries and other stakeholders in Kulob were poorly informed (or misinformed) about OST, which was one of the main reasons for strong opposition to OST.

### **To what extent are project models and results sustainable?**

The major issue in terms of sustainability of project models and results in Tajikistan relates to the inability of the state to assume responsibility for the funding of the Dialogue Project-supported network of partners and services once the project is completed. At all meetings in Tajikistan, partners stressed that the prospect of state funding of harm reduction services was out of question in the foreseeable future. Currently, VCT is being funded through Global Fund grants, although in the recent past there was a shortage of tests and the Republican AIDS Centre was unable to provide VCT to all project-referred clients. Similarly, TB films were donated to national TB facilities by Project HOPE. Against this backdrop,

the Ministry of Health of Tajikistan issued a decree that authorized the transition to a fee-based health care system, with vulnerable population groups ineligible for free testing and care services in most of the cases. This primarily affects STI and TB testing and diagnosis.

Furthermore, another issue faced by Tajik NGOs since late 2011 was related to the requirement of the State National Agency for Pharmaceutical Goods Control to obtain a pharmaceutical activities license for distribution of HIV and overdose prevention commodities (needles and syringes, naloxone). Although the Agency subsequently agreed to suspend the enforcement of that requirement at least until the end of 2012, with such structural obstacles in place vulnerable populations would not be able to receive most of the testing and care services for free at the end of the project; in addition, the classification of needle and syringe distribution among vulnerable populations as a 'pharmaceutical activity' will considerably increase the cost of harm reduction services. In light of this, there are two key sustainability and advocacy priorities in Tajikistan: (1) The inclusion of vulnerable populations in the list of groups of populations eligible for free testing and treatment at state health care facilities; and (2) Exemption from the requirement for NGOs to obtain a license for distribution of needles and syringes, naloxone and other harm reduction and HIV prevention materials. Furthermore, in some meetings with the evaluation team, implementing partners discussed engaging in some sort of income-generating activities as a sustainable way to support their harm reduction and HIV prevention services. Providing support and training to build NGO capacities for raising funds for and implementing income-generating activities might be another way to ensure greater sustainability of the Dialogue Project results.

At all meetings with implementing partners, they emphasized that the models used within the Dialogue Project were relevant and considered as best practices. In particular, the UNISON multidisciplinary approach to treatment adherence among PLHIV model was very highly praised in terms of considerably improving the care of PLHIV. Furthermore, the inclusion of naloxone distribution and provision of trainings on overdose prevention were highlighted as very important elements of the Dialogue Project activities focused on people who inject drugs. While the complexities in measuring the effectiveness of the Break the Cycle Model in preventing initiation of drug injection were well appreciated by programmatic staff and outreach workers, the interviews that the team had in Tajikistan suggest that this model was still appropriate and appealing to many clients.

### **How effectively has the project addressed the integration of HIV/TB/drug treatment?**

In Tajikistan, all implementing partners emphasized that one of their key priorities is to refer clients to HIV and TB testing and treatment and to address their need of drug treatment services, whenever applicable. In Kulob, NGO Anis operates a drop-in center for clients with drug dependency and is also providing rehabilitation services. In Dushanbe, NGO SPIN Plus has established a drop-in center. Through funding from other donors, SPIN Plus also established a low-threshold site for women drug users, which serves as the only facility in Tajikistan that specializes on addressing specific needs of women with drug dependency. All implementing partners refer their clients for TB testing and HIV VCT, and escort the majority of their clients to respective state institutions, where friendly doctors offer these services without making project clients wait in long lines.

In interviews with implementing NGO partners and the Consortium members, all welcomed the introduction of a voucher system by the Dialogue Project and suggested that it was accepted by service providers. Although the Ministry of Health and the Republican AIDS Center use a different voucher for VCT, Dialogue Project clients are able to receive VCT with the Dialogue voucher, which can either be used on its own or, as in case with NGO Marvorid, in combination with the Tajik Ministry of Health-approved voucher. The provision of free TB testing and treatment through the Dialogue Project was

highly appreciated by all implementing partners and the clients with whom the team has met, and was often highlighted as a unique feature of the project.

One of the key enabling factors in regards to integration of HIV/TB/drug treatment is the availability of opioid substitution therapy (OST) in TB in-patient facilities. While OST is available at three pilot sites (Dushanbe, Khujand, Khorog) in Tajikistan, it is only available at specialized state-run drug treatment dispensaries and is not available in TB facilities.

Furthermore, despite the Dialogue Project's focus on training community leaders in supporting adherence to TB treatment, the active role of community leaders in this area was hardly ever mentioned during the evaluation interviews in Tajikistan. Instead, outreach and/or social workers were usually mentioned in the context of supporting TB adherence.

**Priorities to address in the remaining two years:**

1. Focus on sustainability of project models and results by:

- building partners' capacities in fund raising and, possibly, in implementing income-generating activities
- advocating for vulnerable populations to be eligible for free testing and/or treatment
- advocating for an exemption from the requirement for NGOs to obtain a pharmaceutical activities license in order to be able to distribute naloxone, needles and syringes (and other medical commodities) to vulnerable populations
- continuing the Dialogue with the Ministry of Health of Tajikistan on adoption of the Dialogue Project-developed voucher system
- strengthening the MDT component;
- increasing implementing partner capacity in using the project MIS

2. Seek greater involvement of the country level working group in addressing advocacy and sustainability issues.

3. Jointly with Quality Health Care Project, advocate for expansion of OST to Khatlon Region (along with providing an extensive amount of trainings on various aspects of OST to a broad range of stakeholders), and for making OST available at TB in-patient facilities.

4. Make a decision whether to focus more on quality of services to clients that have already been reached rather than on reaching an increased number of new clients.

5. Address police harassment, abuse and violence towards vulnerable populations.

6. Provide more IEC materials in Tajik language, ideally using plain language, as quite often both outreach workers and beneficiaries have only basic levels of education.

7. If possible, provide support to SPIN Plus-run drop-in center for female drug users, as this is the only facility in the country that is able to address a wide variety of their specialized needs.

## Annex IV: Unmet needs of implementers

During the in-country visits and particularly in the discussions with the implementing partners, a range of needs were articulated by the NGOs that would better assist them to deliver the Dialogue Project models. Most of the needs identified related to capacity building for sustainability of NGOs in Kazakhstan, which were perceived as those who most need this technical assistance.

In no particular order, the following capacity building needs were identified by implementing partners:

- Organizational management (NGO 'Plus Center,' Osh, Kyrgyzstan)
- Financial management, accounting (NGO 'Umit,' Karaganda, Kazakhstan)
- Advocacy on local level (NGO 'Umit,' Karaganda, Kazakhstan)
- Fundraising, application for state funding (NGO 'Umit,' Karaganda, Kazakhstan; and in Tajikistan, NGO "Anis," Kulob; NGO "Spin Plus")
- Burn out prevention (NGO 'Shapagat,' Temirtau, Kazakhstan; NGO "Anis," Kulob, Tajikistan)
- MIS Database use refresher course (NGO 'Plus Center,' Osh, Kyrgyzstan)
- Gender equity approach to services for PWID (NGO 'Umit,' Karaganda, Kazakhstan; NGO "Spin Plus," Dushanbe, Tajikistan)
- Different methods of involvement of PWID into prevention programs, PDI (NGO 'Plus Center,' Osh, Kyrgyzstan)
- Motivational counseling for outreach workers (NGO 'Pravo na zhizn,' Bishkek, Kyrgyzstan; NGO "Anis," Kulob, Tajikistan)
- VCT counseling skills for outreach workers (NGO 'Antistigma,' Kant, Kyrgyzstan; NGO 'Shapagat,' Temirtau, Kazakhstan)
- Psychological aspects of counseling prisoners (NGO 'Rans Plus,' Bishkek, Kyrgyzstan)
- Refresher trainings of outreach workers on every relevant topic (social support, case management, ARV adherence, BTC, HIV/TB) – all NGOs. There are continually new developments in the HIV and TB fields; therefore, training is always relevant.
- Experience exchange visits to Ukrainian MDT programs – all NGOs who work with PLHIV
- Incorporating Internet and cell phone technologies into MSM prevention interventions (NGO "Legal Support," Dushanbe, Tajikistan)

Other technical assistance to NGOs:

- Technical assistance in organization of in-service training for new outreach workers (on every relevant topic, including OD prevention, BTC, MAT, TB/HIV)
- Developing a sustainability road map for each implementing partner
- Organizational strategic planning

Technical assistance on building partnerships:

- Continuous education and refresher trainings for law enforcement personnel in the lower ranks (street patrols), prevention of punishment PWID for carrying syringes and naloxone vials, prevention of discrimination and abuse of sex workers and MSM
- Assistance in building partnerships on a local level with key stakeholders

Human resource issues:

- Salary levels for outreach workers are too low to encourage long term commitment to project and also inconsistent with salary levels for Global Fund funded outreach workers.

Commodities:

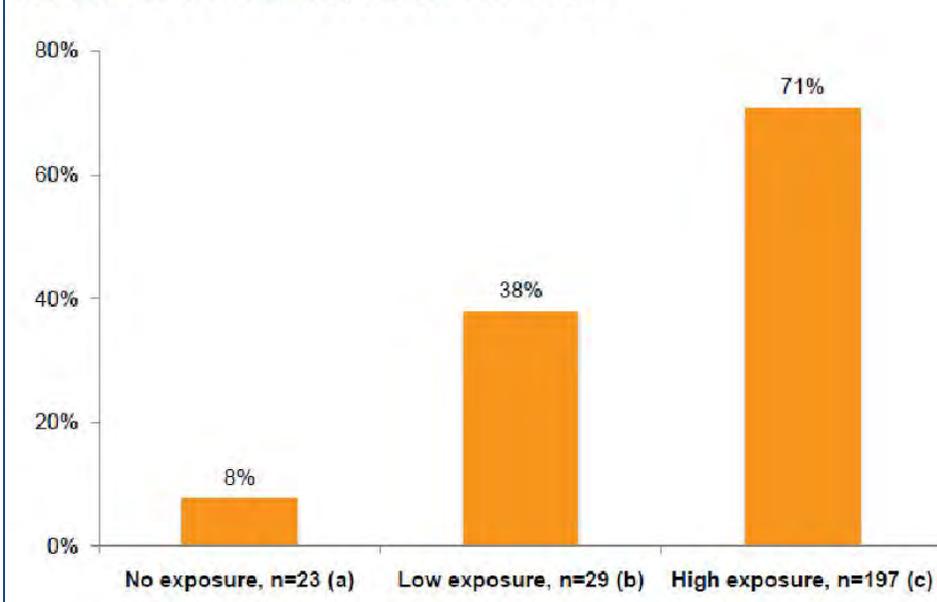
- Shelves for reports / display racks for IEC material – all implementing partners
- Safe-deposit boxes – NGO 'Plus Center,' Osh
- Information boards – MDT, Almaty City AIDS Center

In addition, several NGOs expressed the need to have their own office facilities, since they are anxious about having no funds to rent them when donors' support is over.

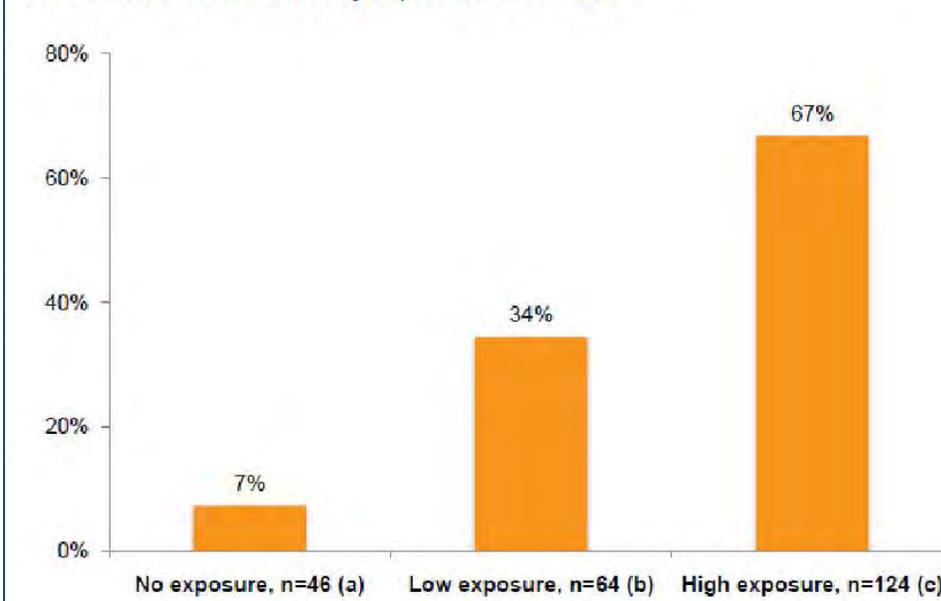
**Recommendation:** A two-year capacity building needs assessment and plan be conducted /developed for each implementing partner.

## Annex V: MSM Data Tables

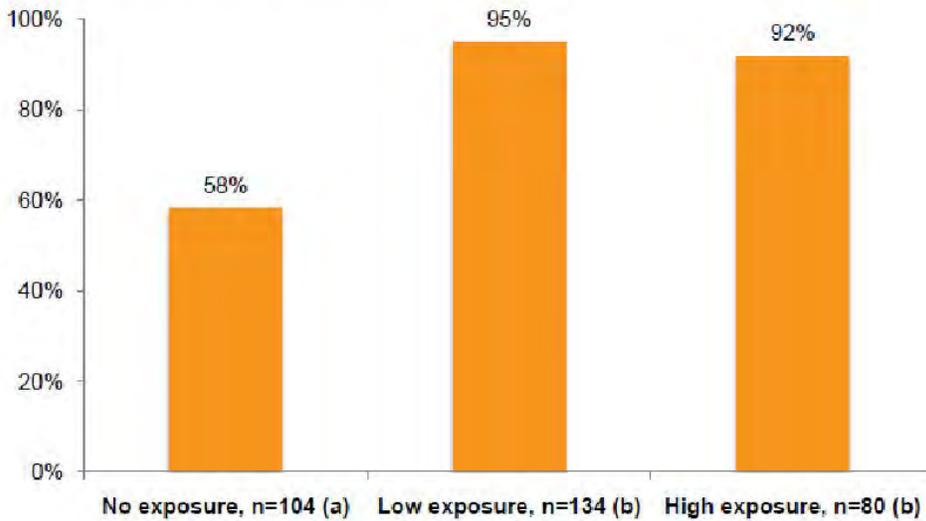
**Figure 9a: Percentage (%) of MSM respondents in Kazakhstan who used a condom from start to finish by exposure level, 2012<sup>12</sup>**



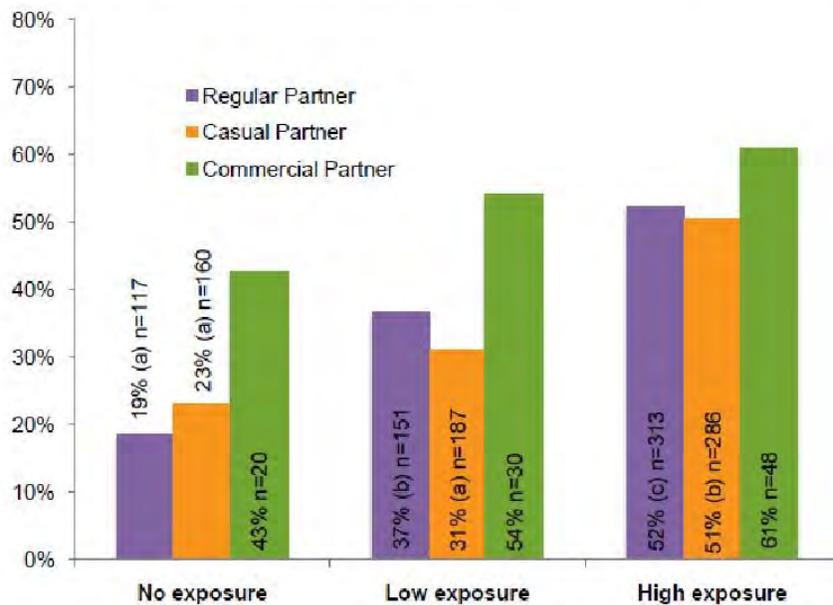
**Figure 9b: Percentage (%) of MSM respondents in Kyrgyzstan who used a condom from start to finish by exposure level, 2012**



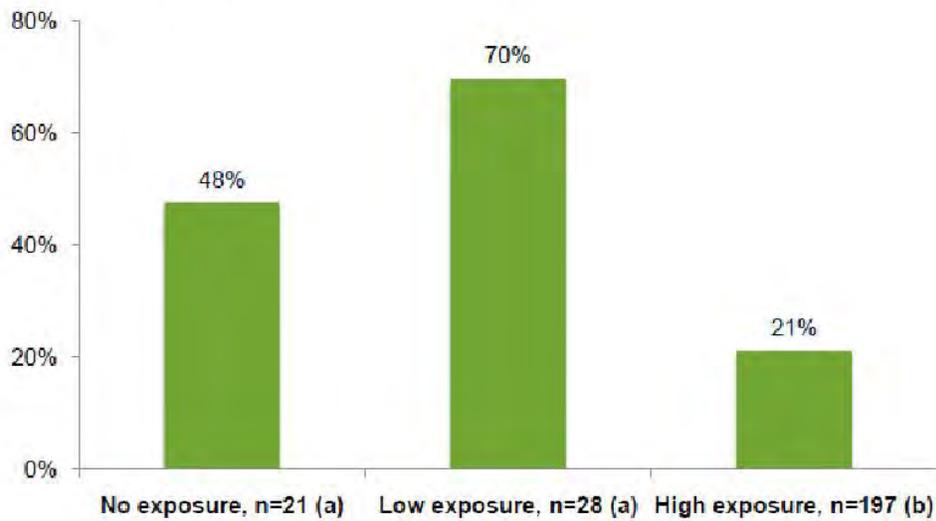
**Figure 9c: Percentage (%) of MSM respondents in Tajikistan who used a condom from start to finish by exposure level, 2012**



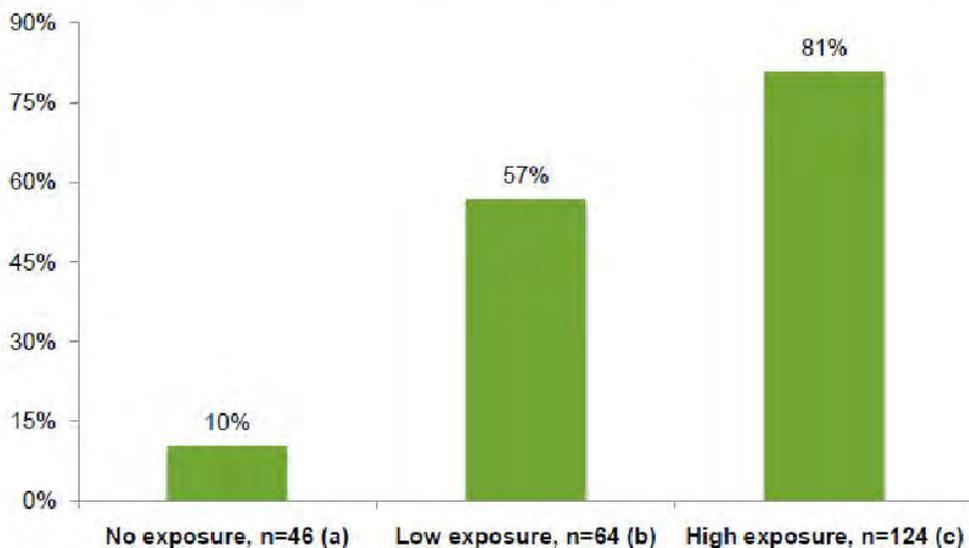
**Figure 10: Percentage (%) of MSM respondents who report always using a condom with regular, casual, and commercial male partners in the last 6 months in CAR by exposure level, 2012**



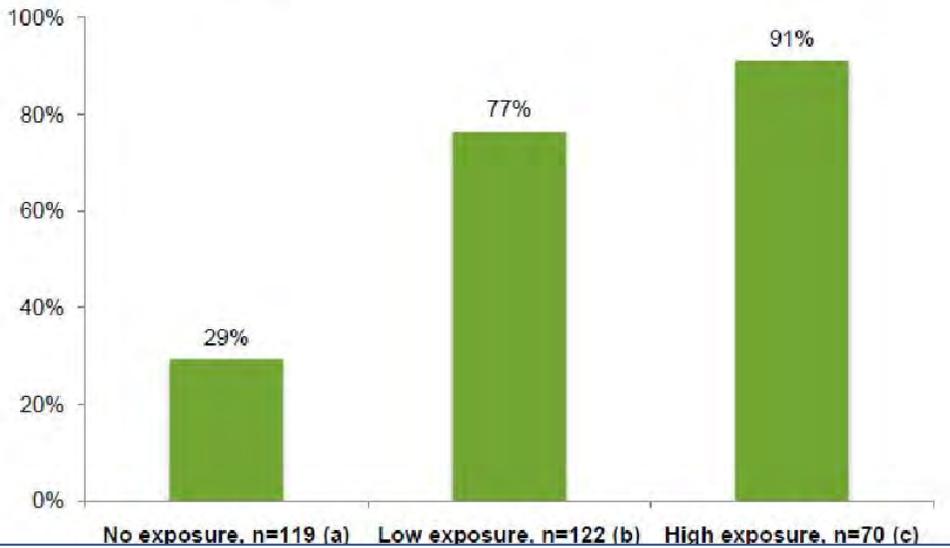
**Figure 11a:** Percentage (%) of MSM respondents who report having been tested for HIV and receiving results in the last 12 months in Kazakhstan by exposure level, 2012.



**Figure 11b:** Percentage (%) of MSM respondents who report having been tested for HIV and receiving results in the last 12 months in Kyrgyzstan by exposure level, 2012.



**Figure 11c: Percentage (%) of MSM respondents who report having been tested for HIV and receiving results in the last 12 months in Tajikistan by exposure level, 2012.**



## Annex VI: Evaluation Schedule

### Evaluation Team:

Team Leader/Senior Evaluation Specialist: Elden Chamberlain  
 HIV/AIDS Technical Advisor: Alisher Latypov  
 Capacity Building Technical Advisor: Karen Johnson Lassner  
 Evaluation Specialist: Katerina Maksymenko

### USAID/CAR/HEO Team:

Head of HEO: Leslie Perry  
 Regional HIV Advisor: Khorlan Izmailova  
 Project Management Specialist/HE/Tajikistan: Dilorom Kosimova  
 Health Project Management Specialist/Kyrgyzstan: Nazgul Chokmorova  
 Regional Strategic Information Advisor: Arman Dairov

Location	Date	Time	Activity/Meeting
Kazakhstan	Sunday, October 28 <sup>th</sup>		Evaluation Team arrives in Almaty
		9:00 - 13:00	<b>Evaluation Team <u>internal</u> meeting</b> <ul style="list-style-type: none"> <li>Revision of draft instruments;</li> <li>Revision of protocol.</li> </ul>
		13:00-14:00	<b>Lunch</b>
		14:00-18:30	<b>Evaluation Team <u>internal</u> meeting</b> <ul style="list-style-type: none"> <li>Revision of schedule;</li> <li>Discussion of documents.</li> </ul>
	Tuesday, October 30 <sup>th</sup>	08:30-13:00	<b>Evaluation Team <u>internal</u> meeting:</b> continue working on items of October, 29 <sup>th</sup>
		13:00-14:00	<b>Lunch</b>
		14:00-16:00	<b>Evaluation Team <u>internal</u> meeting:</b> continue working on items of October, 29 <sup>th</sup>
		15:00– 17:00	<b>USAID Almaty Office (In-Briefing)</b>  Khorlan Izmailova, Regional HIV Advisor  Arman Dairov, Regional Strategic Information Advisor
	Wednesday,	9:00-11:00	GF PIU. Batyrbek Asembekov, GF PIU Manager

	October 31 <sup>st</sup>	11:30 – 13:00	Almaty AIDS Centre
		13:00 – 14:00	<b>Lunch</b>
		14:30-17:30	NGO "Adali" MSM program
	Thursday, November 1 <sup>st</sup>		<p><b>Site visit to Temirtau</b> (via Astana).</p> <p>Temiratau AIDS Centre. MDT Team in conjunction with NGO "Shapagat" PLHIV program</p> <p>Abay - NGO "Kredo" Prisoners Program</p> <p>Karanganda – NGO "Umid" PWID Program</p>
	Friday, November 2 <sup>nd</sup>	1400-1830	<p><b>Dialogue Project Senior Management Team</b></p> <p>Leila Koushenova, Regional Program Director</p> <p>Elmira Imamabakieva, Technical Deputy of Regional Program</p> <p>Shana Aufenkamp, Regional Program Advisor</p> <p>AFEW representative</p> <p>Project HOPE representative</p> <p>Kazakh Association of People Living with HIV representative</p>

**Tajikistan (Elden Chamberlain and Alisher Latypov and Khorlan Izmailova) (Thur-Fri)**

<b>Date</b>	<b>Time</b>	<b>Activity/Meeting</b>	<b>Location</b>
<b>Sunday, November 4<sup>th</sup></b>		Flight to Dushanbe	
<b>Monday, November 5<sup>th</sup></b>	9:00 – 10:00	GF PIU (UNDP)	UNDP Office
	10:30-12:00	NGO "Mavorid" Sex Worker Program	
	1230–15:00	NGO " Vita " Prisoners Program	
	1530 - 1630	Republican AIDS Centre	
<b>Tuesday, November 6<sup>th</sup></b> (Local Holiday)		Drive to Kulob	
<b>Wednesday, November 7<sup>th</sup></b>	0900 - 2000	NGO "Anis" PWID Program PLHIV Program SW Program MSM Program Migrants Program	Kulob
<b>Thursday, November 8<sup>th</sup></b>	0700-1030 1200-1400 1430 – 1700	Drive to Dushanbe NGO "Spin Plus" PLHIV / PWID Programs NGO "Legal Support" MSM Program	Dushanbe
<b>Friday, November 9<sup>th</sup></b>	0900 – 1200       1600 - 1830	Dialogue Consortium PSI AFEW Project Hope International Office for Migration USAID Country office Dilorom Kosimova, Health Project Management Specialist	Dushanbe
<b>Sunday, November 11<sup>th</sup></b>	1100 - 1430	Fly to Almaty	

**Kyrgyzstan (Karen Johnson Lassner and Kateryna Maksymenko of Evaluation Team and Arman Dairov)**

<b>Date</b>	<b>Time</b>	<b>Activity/Meeting</b>	<b>Location</b>
<b>Sunday, November 4<sup>th</sup></b>		Leaving to Bishkek	
<b>Monday, November 5<sup>th</sup></b>	8:30 – 9:30	USAID Country office Lawrence Held, Deputy Director	USAID Country office, Bishkek
	10:00-12:00	GF PIU TB Coordinator HIV Coordinator	UNDP, Bishkek
	12:00–13:30	Lunch	
	13:30–16:00	Republican AIDS Center Ymutkan Jusupovna Chokmorova, Director	Republican AIDS Center, Bishkek
	16:00-17:00	Dialogue Project Office Djamila Alisheva, Country manager	PSI, Bishkek
	16:30-17:30 20:00-21:00	PSI Outreach workers of the MSM component, MSM component coordinator	PSI, Bishkek
<b>Tuesday, November 6<sup>th</sup></b>	9:00 – 12:00	<b>NGO "Rans Plus", prisoners</b> Ibragim Lebusov, Director Outreach workers, trainer	Chui Oblast
	13:00 – 15:00	<b>NGO "Pravo na zhizn", PWID</b> Aibar Sultangaziev, Director Outreach workers, social worker Clients, volunteers	
	16:00-18:00	<b>NGO "Antistigma", PLHIV</b> Maria Vladimirovna, Director	

		STI Doctor/Social worker Outreach workers Clients	
<b>Wednesday, November 7<sup>th</sup> (Local Holiday)</b>	10:00-12:00	NGO "Podruga", SW Nadezhda, Director	Bishkek
<b>Thursday, November 8<sup>th</sup></b>		Leaving to Osh from Bishkek	
	10:00 -12:00	NGO "Plus Center", PWID Ravshan, Director Outreach coordinator Outreach workers Clients	Osh
	14:00 – 15:00	NGO "Podruga", SW Outreach workers Pimp, client	Karasu
	16:00 – 17:00	Osh AIDS Center Director	Osh
		Leaving to Bishkek from Osh	
<b>Friday, November 9<sup>th</sup></b>	13:00 – 16:00	Dialogue Project Country Management Team PSI Kyrgyzstan representatives AFEW representative Project HOPE representative	Bishkek
<b>Saturday, November 10<sup>th</sup></b>		Leaving to Almaty from Bishkek.	

## Almaty, Kazakhstan

<b>Almaty</b>	Sunday, November 11 <sup>th</sup> – Thursday, November 15 <sup>th</sup>		Evaluation Team analyzes and discuss findings and works on Draft Report
	Friday, November 16 <sup>th</sup>	15:00	USAID/HEO – “out brief”
	Saturday, November 17 <sup>th</sup> – Tuesday, November 20 <sup>th</sup>		Team Leader and one member of Evaluation Team work on comments <b>made during USAID/HEO “out brief”</b> . <b>Finalizing Evaluation Report</b>
	Friday, November 23 <sup>th</sup>		In country mission ends Draft Report submitted to USAID CAR & AIDSTAR-Two for Comments
	Friday, November 30 <sup>th</sup>		Report Completed and submitted to MSH editing department
	Friday, December 7 <sup>th</sup>		Final report submitted to USAID CAR

## Annex VII: List of Meetings and Participants

Date	Location	Group	Organization	Participants	Number of participants
<b>KAZAKHSTAN</b>					
Oct 30th, 2012	KZ, Almaty	Donor	USAID	Khorlan Izmailova, Regional HIV Advisor; Arman Dairov, Regional Strategic Information Advisor	2
Oct 31st, 2012	KZ, Almaty	Stakeholders	Republican AIDS Center	Batyrbek Asembekov, GF PIU Manager	1
	KZ, Almaty	PLHIV	City AIDS Center	HCP&Management: Dr. Gulzhakhan Akhmetova, MDT Coordinator	1
				Outreach workers	3
Oct 31st, 2012	KZ, Almaty	MSM	NGO 'Adali'	Management: Vitaly Vinogradov, Outreach Coordinator, Sergej, Director	2
				Outreach workers	3
Nov 1st, 2012	KZ, Temirtau	PLHIV	NGO 'Shapagat'	Management: Zoya Ruzhnikova, Outreach Coordinator	1
				Outreach workers	3
				HCPs: HIV specialist and Nurse	2
				Clients	5
Nov 1st, 2012	KZ, Karaganda	PWID	NGO 'Umit'	Management: Project coordinator, Outreach coordinator	2
				Outreach workers, Social worker	4
				Clients	3
Nov 1st, 2012	KZ, Karaganda	Prisoners	NGO 'Kredo'	Management: Project Coordinator	1
				Outreach workers	3
				Clients	2
Nov 2nd, 2012	KZ, Almaty	Project Consortium	PSI CAR, AFEW, Project HOPE, Kazakhstan Union of PLWH	Nurali Amanzholov, Altinay Rsaldinova, Irina Yuzkaeva, Leila Koushenova, Mira Sauranbayeva, Shanna Aufenkamp, Elmira Imambakieva, Irada Nurasheva, Marat Bakpayev	9

<b>KYRGYZSTAN</b>					
Nov 5th, 2012	KG, Bishkek	Donor	USAID	Lawrence Held, Deputy Director	1
Nov 5th, 2012	KG, Bishkek	Stakeholders	UNDP, GF PIU	Management: Oksana Shubina, HIV Grant Coordinator; Irina Schelokova, TB Grant Coordinator	2
Nov 5th, 2012	KG, Bishkek	Stakeholders	Republican AIDS Center	HCPs& Management: Ymutkan Jusupovna Chokmorova, Director; Epidemiologist	2
Nov 5th, 2012	KG, Bishkek	MSM	PSI	Management: Outreach coordinator	1
				Outreach workers	3
Nov 6th, 2012	KG, Chui oblast	Prisoners	NGO 'Rans Plus'	Management: Outreach coordinator	1
				Outreach workers, Trainer	4
Nov 6th, 2012	KG, Chui oblast	PWID	NGO 'Pravo na zhizn'	Management: Aibar Sultangaziev, Director	1
				Outreach workers, Social worker	5
				Clients	7
Nov 6th, 2012	KG, Chui oblast	PLHIV	NGO 'Antistigma'	Management: Maria Vladimirovna, Outreach coordinator	1
				HCPs: Diljarom, STI Specialist	1
				Outreach workers	2
				Clients	2
Nov 7th, 2012	KG, Bishkek	SW	NGO 'Podruga'	Management: Project coordinator	1
Nov 8th, 2012	KG, Karasu			Outreach workers	2
				Clients	1
Nov 8th, 2012	KG, Osh	PWID	NGO 'Plus Center'	Management: Ravshan, Director; Elmira, Outreach coordinator	2
				Outreach workers	2
				Clients	
Nov 8th, 2012	KG, Osh	Stakeholders	Osh AIDS Center	HCPs & Management: Elmira Baltabaeva, Head doctor	1
Nov 9th, 2012	KG, Bishkek	Project Consortium	PSI CAR, AFEW, Project HOPE	Djamila Alisheva, Aisha, Mahabat, Ulan, Dina, Nurdin Almirekov	6

<b>TAJIKISTAN</b>					
Nov 5th, 2012	Dushanbe, TAJ	Stakeholders	UNDP, GFATM PIU	Ulugbek Aminov, HIV project manager	1
Nov 5th, 2012	Dushanbe, TAJ	SW	NGO Marvorid	Mahmud Madjidov, Director, and a group of staff, outreach and social workers and clients	10
Nov 5th, 2012	Dushanbe, TAJ	Prison inmates	NGO Vita	Olga Muravlyova, Head of the organization, and three other staff members	4
Nov 5th, 2012	Dushanbe, TAJ	Stakeholders	Republican AIDS Centre	Alidjon Soliev, M&E Specialist	1
Nov 6-7th, 2012	Kulyab, TAJ	PWID, MSM, SW, Migrants	NGO Anis	Idimo Kholmurodova, Director; Rustam Bozorov, Project Coordinator; Bekmurodova Iqbolbi, Drop-in Center Coordinator; 6 clients of drop-in center; outreach workers; social workers; project beneficiaries (PWID, MSM, sex workers, migrants)	40
Nov 8th, 2012	Dushanbe, TAJ	PWID	NGO SPIN Plus	Alisher, and other staff members, including social workers, outreach workers, database specialist, drop-in center clients, MDT members	15
Nov 8th, 2012	Dushanbe, TAJ	MSM	NGO Legal Support	Aziza Pirova, Director, and other staff members, including project coordinator and outreach workers	4
Nov 9th, 2012	Dushanbe, TAJ	Consortium partners	PSI, AFEW, Project Hope, International Office for Migration	Shodiya, Dilshod, Djamilya, Mahina	4
Nov 9th, 2012	Dushanbe, TAJ	Donor	USAID	Dilorom Kosimova, Health Specialist; Khorlan Izmailova, Regional HIV Advisor; Britt, Gender Specialist	3
Total:					177



## Annex IX: Select Bibliography

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- Dialogue Year 3 Annual Report. 2012
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